

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345493	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/19/2017
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 104 COLLEGE DRIVE FLAT ROCK, NC 28731		
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F 000	<p>INITIAL COMMENTS</p> <p>1. 483.10 and 483.12 (F221) at J Immediate Jeopardy began on 11/15/17 when Resident #1 had his head stuck in the left side rail at the head of his bed and had to be released from inside the side rail by fire rescue personnel. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>2. 483.20 (F278) at J Immediate Jeopardy began on 10/24/17 when on the admission MDS side rails were not coded as a restraint for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>3. 483.20 and 483.21 (F279) at J Immediate Jeopardy began on 11/06/17 when the facility failed to develop a comprehensive care plan for the use of side rails for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/13/2017

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 000	<p>Continued From page 1 not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>4. 483.25 (F323) at J Immediate Jeopardy began on 11/15/17 when Resident #1 had his head stuck in the left side rail at the head of his bed and had to be released from inside the side rail by fire department personnel. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>5. 483.70 (F490) at J Immediate Jeopardy began on 10/24/17 when on the admission MDS side rails were not coded as a restraint for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of E (Pattern with no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>6. 483.75 (F520) at J Immediate Jeopardy began on 11/06/17 when the facility failed to develop a comprehensive care plan for the use of side rails for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and</p>	F 000			

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F 000	Continued From page 2 severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.	F 000			
F 221 SS=J	<p>A partial extended survey was conducted as part of the facility's survey from 11/16/17 to 11/19/17. Event ID # 2WHC11.</p> <p>RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2)</p> <p>§483.10(e) Respect and Dignity.</p> <p>The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.</p> <p>(a) The facility must-</p> <p>(1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical</p>	F 221		1/2/18	

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F 221	<p>Continued From page 3</p> <p>symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and physician and staff interviews the facility failed to provide an environment free from restraints when a resident (Resident #1) got his head stuck in the side rail of his bed and his head had to be released from inside the side rail by fire rescue personnel in 1 of 81 beds with side rails with openings that had the potential for entrapment out of a total of 130 beds in the facility.</p> <p>Immediate Jeopardy began on 11/15/17 when Resident #1 had his head stuck in the left side rail at the head of his bed and had to be released from inside the side rail by fire rescue personnel. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 10/17/17 with diagnoses which included high blood pressure, septicemia (blood poisoning), difficulty swallowing and acute pyelonephritis (bacterial infection of the kidney).</p> <p>A review of an admission Minimum Data Set</p>	F 221	<p>On 11/15/17 at approximately 6:30AM resident # 1 (Room 108B) was found by an employee #1. Employee #1, the NA/MA, was working as his medication aide on the 100 hall. She had been working the 7PM to 7AM shift. She was on the 100 hall from 11PM to 7AM. Employee #1 was in room 108 B @ 5:30AM and resident #1 was in the bed with his head elevated at approximately 45 degrees. Employee #1 gave him his morning medications and noted nothing abnormal about the resident. Employee #1 returned to room 108 B at approximately 6:30 AM to check his blood pressure. At that time, Employee #1 noted the top of resident #1's head up to the bridge of his nose was stuck through the side rail on the left side of his bed and his legs were still in the bed. The side rails on both sides of his bed were up. He was on an air mattress. He was talking and answering questions that Employee #1 was asking him. Employee # 1 did not attempt to assist resident #1 at that point. Employee #1 immediately stepped outside the door and asked Employee # 2 (CNA) to get a nurse. Nurse #1, LPN, and Nurse #2 LPN arrived to room 108B within a minute and arrived within seconds of each other. Both assessed the situation and realized the resident had his head up to</p>		

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F 221	<p>Continued From page 4</p> <p>(MDS) dated 10/24/17 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for bed mobility and transfers.</p> <p>A facility document titled Initial or Annual Side Rail Assessment dated 10/18/17 indicated Resident #1 had half-rails times (x) 2 sides, was able to participate appropriately in decision making, was not able to get out of bed independently and desired to have side rails in raised position while in bed. The document further indicated Resident #1 was alert and oriented for bed mobility and needed total assistance from care givers. A section labeled Side Rail Conclusions indicated side rails defined the perimeter of the bed, side rails do not prevent resident from getting out of bed, side rails are not considered a restraint, and side rails are not considered a restraint while in use.</p> <p>During an interview on 11/17/17 at 3:56 PM, Nurse #4 explained nurses were expected to complete a side rail assessment when a resident was admitted and again when readmitted if the resident was out of the facility greater than 24 hours. She confirmed she had completed a side rail assessment for Resident #1 on 10/18/17 and explained she indicated Resident #1 was able to participate appropriately in decision making because he could hold onto the side rail and it was easy for staff to turn him and change him and reposition him because of the side rails on the bed. She stated she thought side rails defined the perimeter of the bed and she thought they were safe. She explained she had indicated Resident #1 desired to have side rails in raised position in bed because that was what she</p>	F 221	<p>the bridge of his nose stuck in the side rail. Nurse #1 left the room to get a lubricant. Nurse #1 returned with the lubricant and both nurses began to move his legs off of the bed to line his body up. They worked to free resident #1 from the side rail for approximately 5 minutes. He began to say he was hurting. The nurses stopped and Nurse #2 LPN called 911. EMS arrived at approximately 6:45am. The nursing staff, EMS and the fire department repositioned the resident in the bed and his head freed from the side rail easily. EMS assessed the resident and left the facility. Resident was evaluated by Nurse #2 (LPN). Redness was noted to bridge of the nose and left cheek. Resident #1 remained 1:1 until a new bed arrived.</p> <p>Resident #1's medical professional was notified of the incident at 7:00AM on 11/15/17. NP was notified that resident # 1 was 1:1. She stated a medical professional would be in later on 11/15/17 to assess resident #1. No orders were given. The RP was notified of the incident at 7:15AM on 11/15/17. ADON pulled a facility census and identified all residents' cognitive status to determine appropriateness of side rails. The ADON then did a facility assessment to determine all residents were safe. MD was in the facility on 11/15/17 at approximately 8:50 AM and assessed the resident.</p> <p>The ADON was in the facility at the time of the incident. The Administrator was notified of the incident by the ADON at 7:13 AM on 11/15/17. The Director of</p>		

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F 221	<p>Continued From page 5</p> <p>usually put on the assessment. She stated she would consider a side rail to be a restraint when a resident could not get out of bed by themselves. She then confirmed Resident #1 could not get out of bed by himself and stated when he got his head stuck in the side rail then it was a restraint. She stated every resident had side rails on their bed and residents' used them to get in and out of bed. She further stated she had received no training in the facility to determine the length of side rails but based on her nursing experience the side rails that were on Resident #1's bed when he got his head stuck were half-length side rails. She explained Resident #1 was calm at times but at other times he moved and squirmed in bed and there were a few times when she had seen him twisted in bed and she and the NAs had repositioned him.</p> <p>A review of an Admission Nursing Evaluation dated 10/25/17 in a section labeled orientation to facility side rails were indicated.</p> <p>Resident #1 had an unplanned discharge to the hospital on 10/31/17 and was readmitted to the facility on 11/04/17.</p> <p>A review of an Admission Nursing Evaluation dated 11/04/17 indicated in a section labeled orientation to facility Resident #1 was unable to be oriented.</p> <p>A facility document titled Initial or Annual Side Rail Assessment dated 11/04/17 indicated Resident #1 had quarter side rail in use x 2 sides. The assessment further revealed Resident #1 was able to participate appropriately in decision making, was not able to get out of bed independently and desired to have side rails in</p>	F 221	<p>Nursing was notified of the incident by the ADON at 6:40AM on 11/15/17. The Regional Director of Operations was notified by the Administrator of the incident at 7:30 AM on 11/15/17. The Corporate Nursing Team was notified by the Administrator and ADON of the incident by 7:15 AM and a plan of correction was initiated immediately. Resident #1 was placed on 1:1 supervision and remained one on one until his new bed arrived. He was placed in his new bed at approximately 4:00 pm on 11/15/17. After evaluation of the resident in the new bed it was determined that the side rails would not be secured in the down position.</p> <p>On November 15, 2017 we assessed all residents for safe use of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition. The assessments were complete on 11/15/17.</p> <p>All residents that are on a high low bed/air mattresses were assessed for proper use of side rails.</p> <p>An in-service with the nursing department was done by the unit manager and ADON: proper use of side rails related to mental status and not to remove the zip ties (No staff has or will work until they have received the in-service). All licensed nursing staff that have worked since the in-service will be educated on the updated side rail assessment. 100% of all staff will be in serviced before they return to work. Side rail assessments reviewed with nurses and to be completed upon</p>		

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F 221	<p>Continued From page 6</p> <p>raised position while in bed. The assessment also revealed Resident #1 had decreased level of consciousness and needed extensive assistance for bed mobility. A section labeled Side Rail Conclusions indicated, side rails do not define the perimeter of the bed, side rails do not prevent resident from getting out of bed, side rails are not considered a restraint, and side rails are not considered a restraint while in use.</p> <p>During an interview on 11/17/17 at 4:37 PM, Nurse #5 explained nurses were expected to complete a side rail assessment with every nursing admission assessment to determine if the side rail was a restraint. She stated they did not use half-length side rails in the facility and only used quarter-length side rails because half-length side rails would be considered a restraint. She explained when she completed Resident #1's side rail assessment on 11/04/17 she determined from a mobility standpoint his preferences for side rails. She stated Resident #1 used the side rail to hold on to when staff repositioned him but he could not turn himself in bed. She further stated Resident #1 would wiggle and squirm in bed at times. She confirmed Resident #1 did not say he desired to have the side rails up but he used them as an aid when turning and repositioning. She stated, in regard to bed mobility, Resident #1 was extensive assist with 2 staff and stated she did not think the side rails defined the perimeter of the bed because the side rails did not cover the whole bed since they were only at the top. She further stated she would consider a side rail to be a restraint when a resident would not be able to get out of bed or the side rail was blocking their exit. She then verified Resident #1 was not able to get out of bed by himself but she had not considered the side rail</p>	F 221	<p>admission, re-admission, quarterly, and with any significant change in the resident's condition.</p> <p>On 11/17/17 100% of all staff prior to assigned shift were in serviced on side rail usage protocol by the dietary manager, therapy manager, administrator, environmental services manager. Side rail management will be added to the general orientation.</p> <p>MDS nursing updated the working plan of care as well as the care plan in chart on all residents that had the side rails secured.</p> <p>All resident care plans were reviewed for appropriate use of side rails and care plans were updated based on results of side rail evaluation.</p> <p>On 11/17/17 Social services, administrative nursing staff and regional clinical manager conducted updated side rail assessments on 100 percent of all residents.</p> <p>Care plans were then updated by DON, ADON and regional clinical manager according to the results of the updated side rail assessment.</p> <p>Maintenance director completed a 100% audit of all residents for the proper bed dimension due to size and weight. Maintenance director also completed an audit of all residents for the risk of entrapment from use of side rails. Notification of updated side rail usage protocol was mailed to the resident and or resident representative on 11/18/17. Side rail assessments will be completed by a licensed nurse upon admission, re-admission, quarterly, and with any</p>		

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F 221	<p>Continued From page 7</p> <p>on Resident #1's bed as a restraint. She stated every bed in the facility had side rails on them and there were different types of beds and side rails.</p> <p>A review of a care plan with a problem onset date of 11/06/17 revealed Resident #1 had activities of daily living (ADL) deficits and impaired physical mobility. The goals indicated in part Resident #1 would remain free from immobility complications and the interventions were listed in part to provide bed mobility and transfers and turn and reposition frequently. There were no interventions documented regarding side rails.</p> <p>A review of a nurse's note documented by Nurse #2 indicated on 11/15/17 at 6:00 AM indicated Nurse Aide (NA) #1 who was also a Medication Aide reported that Resident #1 had his head through the side rail of his bed and was stuck. The notes revealed nurses x 2 applied lubrication to his face in an attempt to slide his head out without success. The notes further revealed 911 was called and the fire department and Emergency Medical Services (EMS) was sent to the facility to attempt to free Resident #1's head without injury. The notes indicated Resident #1 was turned in the bed and his head eventually slid out and there was a red mark and indentation on his left cheek from pressure from the side rail but there was no apparent injury.</p> <p>A review of an incident report dated 11/15/17 at 6:30 AM completed by the Assistant Director of Nursing (ADON) revealed NA#1 entered Resident #1's room to check his blood pressure and Resident #1 was observed with the top of his head in the upper side rail. The report indicated when Resident #1 was asked what he was doing,</p>	F 221	<p>significant change in the resident's condition.</p> <p>The QA Executive Committee will review the results monthly for 3 months.</p>		

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F 221	<p>Continued From page 8</p> <p>he replied he was trying to break his neck, then stated no he was trying to get cooler and get more air. The report further indicated NA#1 attempted to reposition Resident #1 to slip his head from the opening of the rail but Resident #1 was "minimally cooperative." The report revealed lubricant was applied to Resident's #1's head and the fire department was called for assistance on moving Resident #1 and they arrived and assisted with easy removal of his head from the side rail. The report indicated Nurse #2 assessed Resident #1 for injuries and he had redness to his nose and left cheek. The report also indicated half-length side rails were on Resident #1's bed and immediate actions taken were to provide one on one supervision with a staff member and physician and responsible party (RP) were notified.</p> <p>A review of a Fire and Rescue Report dated 11/15/17 at 7:17 AM indicated 2 rescue personnel responded to a call from the facility and Resident #1 had his head stuck in a side rail. The report further indicated rescue personnel had nurses rotate Resident #1's body while they pushed his head toward the mattress in order to free him. The report also indicated there were no injuries or complaints of pain by Resident #1 after his head was released from the side rail.</p> <p>During a telephone interview on 11/16/17 at 4:05 PM, NA #1 who was also a Medication Aide stated she took medications to Resident #1 on 11/15/17 at 5:30 AM and he was fine. She explained she went back into Resident #1's room to take his blood pressure at 6:30 AM and found him lying across the bed with his head in the left side rail and his legs were off the right side of the bed. She stated she asked him what he was</p>	F 221			

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F 221	<p>Continued From page 9</p> <p>doing to get into that position and he said he was trying to break his neck then said he was trying to get some air. She stated he had a nasal cannula with oxygen on and he had an air mattress on his bed which was inflated. She explained she called for Nurse Aides (NAs) #2 and #6 to help and then NA#2 went to get Nurse #1 and Nurse #2. She stated the nurses went and got lubricant and rubbed it on Resident #1's head to try to slide his head out but he wasn't tolerating that well so they stopped and called the fire department and they were able to get Resident #1 repositioned and got his head out of the side rail. She further stated the left side of Resident #1's face was red from the pressure from the bed rail.</p> <p>During a follow up interview on 11/17/17 at 9:12 AM, NA #1 clarified Resident #1 came back to the facility from the hospital at 1:08 AM on 11/15/17 and his blood pressure was high so she was keeping a check on it about every hour. She stated each time she went in his room he was on his back and the head of his bed was elevated approximately 45 degrees and both side rails were raised up at the head of his bed. She explained at 5:30 AM she took his morning meds to him and he was fine and the head of the bed was still up at approximately 45 degrees. She stated at approximately 6:30 AM she went back to check Resident #1's blood pressure and found Resident #1 with his head stuck in the left side rail from the back of his head to the bridge of his nose. She explained Resident #1 did not seem to be in distress and was calm but his head seemed to be really stuck. She explained when Nurse #1 and Nurse #2 were putting lubricant on Resident #1's head and face Resident #1 put his hands on the bed rail and was pulling himself further into the opening of the side rail and they told him to</p>	F 221			

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F 221	<p>Continued From page 10</p> <p>stop pulling on the rail. She explained she and NA #6 were holding Resident #1's legs because they were hanging off the side of the bed and when the fire department and EMS got there they said they had cutters and were going to cut the side rail but when they pulled Resident #1's legs toward the head of the bed and he was straight across the mattress then his head came out of the side rail. She stated side rails were common in the facility and as far as she knew, every resident had side rails on their bed.</p> <p>During an interview on 11/17/17 at 6:45 AM, NA #2 stated she worked the night shift on 11/15/17 and made rounds around 5:20 AM with NA #6 and checked on Resident #1 and at that time Resident #1 was asleep with oxygen on. She stated she did not know anything had happened until NA #1 told her to get a nurse. She explained NA #1 stayed with Resident #1 and NA #2 told Nurse #1 to go to Resident #1's room. She stated after Nurse #1 went into Resident #1's room she then went to get lubricant and Nurse #1 told her to go get the ADON. NA #2 further stated Resident #1 said he was trying to get fresh air but she did not know how he could have gotten his head stuck in the side rail.</p> <p>During an interview on 11/17/17 at 7:05 AM, NA #6 stated on 11/15/17 she assisted NA #2 and they had checked Resident #1 during their last round around 5:20 AM and he was lying on his left side. She explained later she was coming off her assigned hall when NA #1 motioned for her to come to Resident #1's room. She explained when she got to Resident #1's room he had his head caught in the left side rail. She stated Resident #1 said he was looking for fresh air and they tried to get his head out with lubricant but his</p>	F 221			

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F 221	<p>Continued From page 11</p> <p>head wouldn't budge. She explained they called the fire department and EMS and they came and got his head out and Resident #1 had an indention on the left side of his face from the side rail.</p> <p>During an interview on 11/17/17 at 7:15 AM, Nurse #1 stated on 11/15/17 she walked to a medication room and NA #2 came in and told her NA#1 needed her help in Resident #1's room. She explained she walked into Resident #1's room and he was lying on his left side with his head stuck inside the side rail. She stated she asked Resident #1 why his head was stuck in the side rail and he said it is cooler on the other side. She explained she told Resident #1 she was going to get some stuff to lubricate his head and free him and then she met Nurse #2 and took her to Resident #1's room and they put the lubricant on his head but it didn't work to get his head out of the side rail. She stated she told someone but could not remember who to go get the ADON and she came in Resident #1's room and they decided to call the fire department and EMS. She explained the only time Resident #1 said anything was when they tried to move him and he said it hurt and his face started to swell.</p> <p>During an interview on 11/16/17 at 11:17 AM, Nurse #2 explained she worked third shift on 11/15/17 and a NA signaled for her to come to Resident #1's room. She stated she could not recall which NA called to her but as she walked by the nurse's station Nurse #1 was coming out of the medication room with a box of lubricant and stated she was going to Resident #1's room. She explained when she entered Resident #1's room he was on his back but leaning toward his left side and his head was stuck in the open part</p>	F 221			

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F 221	<p>Continued From page 12</p> <p>of the left side rail. She stated Resident #1 wasn't talking much but she and Nurse #1 applied lubricant to Resident #1's face and tried to pull him out but it didn't work. She explained NA #2 went to get the ADON to come to Resident #1's room. She stated she thought if they turned Resident #1's body in alignment with his head they could slide him out but that didn't work. She explained the ADON said they should call the fire department and Nurse #2 called 911 and explained the problem and the dispatcher said they would send the fire department and EMS. She stated when the fire department and EMS arrived they turned Resident #1's body to be across the bed and the rescue personnel pushed Resident #1's head back through the rail and his head slid out. She explained Resident #1 had an indentation and a red mark from the side rail on his left cheek but there was no broken skin. She stated she did not know how he got his head stuck in the rail.</p> <p>During an interview on 11/16/17 at 12:09 PM, the ADON explained NA #2 came and got her around 6:30 AM on 11/15/17 and told her to come to Resident #1's room. She stated when she entered Resident #1's room, he was lying sideways in the bed with his upper body toward the left side of the bed and his head was in the left side rail up to the bridge of his nose and his left cheek was pressed into the rail. She explained Resident #1 was groaning and someone had put lubricant on his face and forehead to try to slide his head out but it didn't help. She stated Nurse #2 called 911 and the fire department and EMS came but she wasn't in the room when they got his head out of the side rail. She explained she called the Nurse Practitioner (NP) and was told a physician would be at the</p>	F 221			

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F 221	<p>Continued From page 13</p> <p>facility later that day to see Resident #1. She stated the NP also stated she would talk with the Medical Director to let him know but to continue to provide Resident #1 with one-on-one supervision. The ADON stated she then called Resident #1's RP.</p> <p>During an interview on 11/16/17 at 1:30 PM, Nurse #6 stated she arrived at work on 11/15/17 at 6:45 AM and staff were in Resident #1's room waiting for the fire department and EMS. She explained Resident #1 normally slept a lot during the day but sometimes during the evening he had a tendency to be restless. She stated she had noticed twice lately Resident #1 had his legs thrown over the side of the bed. She stated she asked him why he was restless but he couldn't tell her.</p> <p>During an interview on 11/16/17 at 3:00 PM, NA #3 stated she was told yesterday morning on 11/15/17 around 7:00 AM during report from third shift Resident #1 had his head stuck into the side rail. She explained the left side of his face was a little red yesterday but there was no redness today. She stated she was surprised Resident #1 had his head stuck in the side rail because she had not seen him try to get out of bed.</p> <p>During an interview and observation on 11/16/17 at 1:05 PM, the Environmental Services (EVS) Director stated he was notified about 7:30 AM on 11/15/17 by the ADON that Resident #1 needed a Hi-Low bed because they had a problem with the side rails on his current bed. He stated he went to Resident #1's room and placed zip ties to secure the side rails to the frame of the bed so they could not be pulled back up and then he called the company to order a Hi-Lo bed. He</p>	F 221			

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F 221	<p>Continued From page 14</p> <p>stated the new bed was delivered around 3:45 PM on 11/15/17 and he took the old bed to a service hall with the side rails still attached to the bed. The EVS Director pointed to a bed in the service hallway and confirmed it was the bed he had removed from Resident #1's room. He then raised the left side rail of the bed and measured the diameter of the 2 largest openings of the side rail. He confirmed both of the large openings were 7.5 inches wide X 7.0 inches high.</p> <p>During an interview on 11/16/17 at 2:10 PM, Physician #1 who was also the facility Medical Director stated a NP had called him yesterday morning on 11/15/17 and told him Resident #1 made the statement about wanting to break his neck and asked if we should send him for psychiatric services. He stated Physician #2 saw Resident #1 on 11/15/17 and did not think Resident #1 was a risk to himself. Physician #1 stated he thought Resident #1 had dementia but did not think he was suicidal.</p> <p>During an observation on 11/16/17 at 5:11 PM Resident #1 was sitting up in bed and had no visible red areas or bruises on his face.</p> <p>During an interview on 11/16/17 at 5:40 PM, NA #4 stated Resident #1 was usually confused when she was assigned to his care and he needed total assistance with activities of daily living. She further stated Resident #1 could scoot down in the bed.</p> <p>During an interview on 11/16/17 at 5:55 PM, NA #5 stated she had provided care to Resident #1 and in the past she had seen him with his legs off the left side of the bed and she had to go and reposition him.</p>	F 221			

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F 221	<p>Continued From page 15</p> <p>During an observation on 11/17/17 at 8:05 AM Resident #1 was lying in bed and NA #3 was on the right side of his bed. Resident #1 had his eyes closed and there were no red areas or bruised visible on his face or neck.</p> <p>During a follow up interview on 11/17/17 at 8:29 AM, the EVS Director explained the type of bed Resident #1 had his head caught in the side rail were old beds from a local hospital that were put in the facility years ago. He stated over the years they had purchased some Hi-Low beds and they had side rails with spaces that were much smaller than the old bed side rails. He stated all beds in the facility had side rails on them because beds came delivered with side rails already on them. He explained they had taken the rails off the beds at the foot because if they had rails at the top and foot they would be restraints. He stated he thought the side rail on the bed that Resident #1's head was stuck in was a quarter-length side rail. He stated there were 130 beds in the facility but he did not have an inventory list of the type of side rails on each bed.</p> <p>During an interview on 11/17/17 at 5:11 PM, the MDS Nurse stated there was no place to code side rails on the MDS unless they were used as a restraint. She stated the facility was restraint free and they had never put side rails on a care plan but now she could see that side rails were not adequate for some residents. She stated she visited with Resident #1 after he got his head stuck in the side rail and asked him what had happened and he said he was trying to get out there and get some more air but he was not trying to get out of bed. She explained when she had visited with him in the past and he was lying on</p>	F 221			

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F 221	<p>Continued From page 16</p> <p>his side he had his hand resting on top of the side rail. She stated she thought most of the beds in the facility had side rails on them but they did not use half-length side rails She further stated it was her understanding that side rail assessments were done to determine if the resident wanted the side rails up or down and Resident #1 could answer simple questions but if the questions was complex he had trouble answering them.</p> <p>During an interview on 11/17/17 at 5:39 PM, the Maintenance Director stated every bed in the facility had quarter-length side rails and he thought the side rails were on the beds because that was the way they were delivered. He explained he did maintenance on beds if they squeaked or the brakes didn't work or if the side rails were loose. He confirmed most of the beds in the facility were beds like the one Resident #1 got his head caught in the side rail. He stated newer beds had more compact openings with less space in the openings. He further stated he had not received any work order requests for Resident #1's bed or side rails. He explained the type of bed Resident #1 was in when his head was stuck in the side rail was an older hospital bed manufactured before 1997 because he had found inspection stickers on them from a local hospital dated 1997 and he had ordered replacement parts for the beds that were dated 1996 and 1997.</p> <p>During a follow up interview on 11/17/17 at 5:55 PM, the ADON stated every bed in the facility had quarter-length side rails but if a resident did not want side rails they took them off. She explained a side rail assessment was completed by the nurse when a resident was admitted or readmitted to the facility and the side rail</p>	F 221			

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F 221	<p>Continued From page 17</p> <p>assessment was supposed to determine how the resident used side rails and if the side rails restricted their movements. She stated she knew when Resident #1's head was caught in the side rail it was a problem and if it happened to him it could happen to another resident.</p> <p>During a record review on 11/18/17 at 9:45 AM a service manual for a resident bed revealed the bed was configured to accept sectionalized half-length side rails. The manual further indicated the bed must have the head section side rails because both head section rails contained head and knee controls and hi-low activators to raise the bed up or down.</p> <p>During a follow up interview on 11/18/17 at 10:15 AM, the EVS Director confirmed the service manual for a resident bed was for the same type bed Resident #1 was in when he got his head stuck in the side rail. He also provided a bed audit he had completed on 11/17/17 of all beds in the facility and explained there were 81 beds which were the same type as the bed Resident #1 got his head stuck in the side rail, 33 Hi-Low beds the facility owned, 15 rental beds and 1 personal bed to equal 130 beds in the facility.</p> <p>During an interview on 11/18/17 at 2:57 PM, the Director of Nursing stated she was on vacation earlier in the week but was called by the ADON after Resident #1 got his head stuck in the side rail and she came back to the facility. She further stated she had not considered the side rails on Resident #1's bed to be quarter-length rails but after review of the service manual for the bed she now realized they were half-length side rails. She explained the older beds like the one Resident #1 got his head stuck in the side rail came when the</p>	F 221			

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F 221	<p>Continued From page 18</p> <p>facility was opened years ago. She stated Resident #1 leaned significantly toward his left side regardless of how he was positioned and if his body was in the direction of the side rail with his head near the rail that would have been a red flag. She stated it was her expectation for staff to look and see if the side rail was a positioning device and should not restrict movement of the resident.</p> <p>During an interview on 11/18/17 at 4:05 PM, Physician #1 who was also the facility Medical Director stated he was notified promptly when Resident #1 got his head caught in the side rail. He further stated the incident was a left over to 20 years with use of beds with older side rail designs.</p> <p>During an interview on 11/19/17 at 2:43 PM, the Administrator stated it was his expectation that any kind of equipment needed to be looked at for potential for harm. He stated when he came to work at the facility earlier this year he did not think to look at the assessments of beds or side rails. He stated it was his expectation staff could not let their guard down but needed to protect residents from harm. He further stated he could now see how side rails were beneficial and hazardous and it was his expectation for all staff to be inserviced to make everyone was aware of bed and side rail safety and unsafe zones.</p> <p>The Administrator, ADON, Regional Consultant of Clinical Services and Corporate Consultant of Clinical Services were informed of Immediate Jeopardy on 11/17/17 at 2:33 PM.</p> <p>The facility provided an acceptable credible allegation for immediate jeopardy removal on</p>	F 221			

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F 221	<p>Continued From page 19 11/18/17 at 7:33 PM.</p> <p>Credible Allegation for Hendersonville Health and Rehabilitation for F 221-The resident has the right to be treated with respect and dignity, including: the right to be free from physical restraints. On 11/15/17 Hendersonville Health and Rehab re-evaluated their processes for the use of side rails to ensure all residents are treated with dignity and respect which includes their right to be free from physical restraints as outlined below.</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;</p> <p>On 11/15/17 at approximately 6:30 AM resident # 1 (Room 108 B) was found by an employee #1. Employee #1, the NA/MA, was working as his medication aide on the 100 hall. She had been working the 7 PM to 7 AM shift. She was on the 100 hall from 11 PM to 7 AM. Employee #1 was in room 108 B @ 5:30 AM and resident #1 was in the bed with his head elevated at approximately 45 degrees. Employee #1 gave him his morning medications and noted nothing abnormal about the resident. Employee #1 returned to room 108 B at approximately 6:30 AM to check his blood pressure. At that time, Employee #1 noted the top of resident #1's head up to the bridge of his nose was stuck through the side rail on the left side of his bed and his legs were still in the bed. The side rails on both sides of his bed were up. He was on an air mattress. He was talking and answering questions that Employee #1 was asking him. Employee # 1 did not attempt to assist resident #1 at that point. Employee #1 immediately stepped outside the door and asked Employee # 2 CNA to get a nurse. Nurse #1,</p>	F 221			

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F 221	<p>Continued From page 20</p> <p>LPN, and Nurse #2 LPN arrived to room 108 B within a minute and arrived within seconds of each other. Both assessed the situation and realized the resident had his head up to the bridge of his nose stuck in the side rail. Nurse #1 left the room to get a lubricant. Nurse #1 returned with the lubricant and both nurses began to move his legs off of the bed to line his body up. They worked to free resident #1 from the side rail for approximately 5 minutes. He began to say he was hurting. The nurses stopped and Nurse #2 LPN called 911.</p> <p>EMS arrived at approximately 6:45 AM. The nursing staff, EMS and the fire department repositioned the resident in the bed and his head freed from the side rail easily. EMS assessed the resident and left the facility. Resident was evaluated by Nurse #2 LPN. Redness was noted to bridge of the nose and left cheek. Resident #1 remained 1:1 until a new bed arrived.</p> <p>Resident #1's medical professional was notified of the incident at 7:00 AM on 11/15/17. NP was notified that resident # 1 was one on one supervision. She stated a medical professional would be in later on 11/15/17 to assess resident #1. No orders were given. The RP was notified of the incident at 7:15AM on 11/15/17. ADON pulled a facility census and identified all residents' cognitive status to determine appropriateness of side rails. The ADON then did a facility assessment to determine all residents were safe. MD was in the facility on 11/15/17 at approximately 8:50 AM and assessed the resident.</p> <p>The ADON was in the facility at the time of the incident. The Administrator was notified of the</p>	F 221			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345493	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/19/2017
NAME OF PROVIDER OR SUPPLIER HENDERSONVILLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 104 COLLEGE DRIVE FLAT ROCK, NC 28731		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	<p>Continued From page 21</p> <p>incident by the ADON at 7:13 AM on 11/15/17. The Director of Nursing was notified of the incident by the ADON at 6:40 AM on 11/15/17. The Regional Director of Operations was notified by the Administrator of the incident at 7:30 AM on 11/15/17.</p> <p>The Corporate Nursing Team was notified by the Administrator and ADON of the incident by 7:15 AM and a plan of correction was initiated immediately.</p> <p>o The procedure for implementing the acceptable plan of correction for the specific deficiency cited;</p> <p>Resident #1 was placed on one on one supervision and remained one on one until his new bed arrived. He was placed in his new bed at approximately 4:00 PM on 11/15/17. After evaluation of the resident in the new bed it was determined that the side rails would not be secured in the down position.</p> <p>On November 15, 2017 we assessed all residents for safe use of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition. The assessments were complete on 11/15/17.</p> <p>All residents that are on a high low bed/air mattresses were assessed for proper use of side rails.</p> <p>An in-service with the nursing department was done by the unit manager and ADON: proper use of side rails related to mental status and not to remove the zip ties (No staff has or will work until they have received the in-service). All licensed</p>	F 221			

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F 221	<p>Continued From page 22</p> <p>nursing staff that have worked since the in-service will be educated on the updated side rail assessment. 100% of all staff will be in serviced before they return to work. Side rail assessments reviewed with nurses and to be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition.</p> <p>On 11/17/17 100% of all staff prior to assigned shift were in serviced on side rail usage protocol by the dietary manager, therapy manager, administrator, environmental services manager. Side rail management will be added to the general orientation.</p> <p>MDS nursing updated the working plan of care as well as the care plan in chart on all residents that had the side rails secured.</p> <p>All resident care plans were reviewed for appropriate use of side rails and care plans were updated based on results of side rail evaluation.</p> <p>On 11/17/17 Social services, administrative nursing staff and regional clinical manager conducted updated side rail assessments on 100 percent of all residents.</p> <p>Care plans were then updated by DON, ADON and regional clinical manager according to the results of the updated side rail assessment.</p> <p>Maintenance director completed a 100% audit of all residents for the proper bed dimension due to size and weight. Maintenance director also completed an audit of all residents for the risk of entrapment from use of side rails.</p> <p>Notification of updated side rail usage protocol will be mailed to the resident and or resident representative by 11/18/17.</p> <ul style="list-style-type: none"> o The monitoring procedure to ensure that the plan of correction is effective and that specific 	F 221			

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F 221	Continued From page 23 deficiency cited remains corrected and/or in compliance with the regulatory requirements; 1. We assessed all residents for safe use of side rails. 2. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition. The title of the person responsible for implementing the acceptable plan of correction. Director of Nursing and Administrator We certify that as of November 18, 2017 the immediate jeopardy will be removed. Immediate Jeopardy was removed on 11/18/17 when interviews with nurses and NA's validated they were aware of proper use of side rails related to a resident's mental status and use of new side rail assessments. They also confirmed they had been inserviced on the side rail usage protocol and resident care plans had been updated regarding use of side rails. Administrative staff were also interviewed and stated they had been inserviced on side rail assessments and new assessments had been completed for every resident in the facility. They stated they were aware they were to report any concerns regarding side rails on resident beds to Administration immediately. An interview with the EVS Director and Maintenance Director confirmed they had received inservice education and had audited 100% of resident beds for the risk of entrapment from side rails.	F 221			
F 278 SS=J	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j)	F 278		1/2/18	

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F 278	<p>Continued From page 24</p> <p>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) of a resident for use of side rails as a potential restraint. The resident (Resident</p>	F 278	<p>On 11/4/17 Resident #1 was assessed by the licensed admissions nurse using the Sanstone side rail assessment from the electronic medical record. Resident was</p>		

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F 278	<p>Continued From page 25</p> <p>#1) got his head stuck in the side rail of his bed and his head had to be released from inside the side rail by fire rescue personnel for 1 of 4 sampled residents who had side rails on their beds.</p> <p>Immediate Jeopardy began on 10/24/17 when on the admission MDS side rails were not coded as a restraint for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 10/17/17 with diagnoses which included high blood pressure, septicemia (blood poisoning), difficulty swallowing and acute pyelonephritis (bacterial infection of the kidney).</p> <p>A review of an admission Minimum Data Set (MDS) dated 10/24/17 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for bed mobility and transfers and side rails were not coded as a restraint.</p> <p>A facility document titled Initial or Annual Side Rail Assessment dated 10/18/17 indicated Resident #1 had half side rails on each side of the bed at the head of the bed. The document further indicated Resident #1 needed total assistance</p>	F 278	<p>assessed and consider safe for side rail usage.</p> <p>Following the incident with resident #1 the Director of Clinical Operations updated the Sanstone Health and Rehab side rail evaluation to include the (residents cognitive status, bed mobility status, danger zone status and the proper bed sizing status) to be completed by the licensed nurses upon admission, readmission, significant change in condition and quarterly to ensure a more accurate evaluation of resident safety. On 11/18/17 a 100% audit was completed by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. On 11/18/17 a 100% MDS audit was completed by the by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. On 11/18/17 100% MDS nurses were re-educated by the DON/ADON on accurate coding of the MDS assessments according to the RAI manual.</p> <p>On 11/18/17 a 100% audit was completed by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. On 11/18/17 a 100% MDS audit was completed by the by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. Any negative findings were addressed by the DON, ADON, Unit Manager, maintenance director and environmental services director to assure resident safety.</p>		

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F 278	<p>Continued From page 26 from care givers.</p> <p>During an interview on 11/17/17 at 3:56 PM, Nurse #4 confirmed she had completed a nursing admission assessment and a side rail assessment for Resident #1 but did not do any coding on MDS assessments. She explained she had documented on the admission nursing assessment that side rails were indicated for Resident #1 because it was her (Nurse #4) usual routine to check the side rails box since all resident beds had side rails on them. She stated she had not considered the side rails on Resident #1's bed to be a restraint but when he got his head stuck in the side rail then she felt they were a restraint.</p> <p>Resident #1 had an unplanned discharge to the hospital on 10/31/17 and was readmitted to the facility on 11/04/17.</p> <p>A facility document titled Initial or Annual Side Rail Assessment dated 11/04/17 indicated Resident #1 had quarter length side rails on both sides of his bed at the head of the bed. The document further revealed Resident #1 had decreased level of consciousness and needed extensive assistance for bed mobility.</p> <p>During an interview on 11/17/17 at 4:37 PM, Nurse #5 confirmed she completed an admission nursing assessment for Resident #1 on 11/04/17 because he had been gone to the hospital for 3 days. She stated she did not do any coding on an MDS. She stated she would consider a side rail to be a restraint when a resident would not be able to get out of bed or the side rail was blocking their exit.</p>	F 278	<p>Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition by a licensed nurse. Identified problems will be addressed by the DON, ADON, Unit Manager, licensed nurse, maintenance director and or environmental services director.</p> <p>On 11/18/17 100% MDS nurses were re-educated by the DON/ADON on accurate coding of the MDS assessments according to the RAI manual. DON and ADON will audit residents MDS assessments for accuracy x 2 weeks. Then 50% will be audited x 2 weeks, then 10% weekly x 4. The results of the audits will be reviewed weekly by the Regional Clinical Manager x 8 weeks to ensure the facility is in compliance with F278.</p> <p>The QA Executive Committee members will review results monthly X 3 months.</p>		

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F 278	<p>Continued From page 27</p> <p>A review of an incident report dated 11/15/17 at 6:30 AM completed by the Assistant Director of Nursing (ADON) revealed NA#1 entered Resident #1's room to check his blood pressure and Resident #1 was observed with the top of his head in the upper side rail. The report indicated when Resident #1 was asked what he was doing, he replied he was trying to break his neck, then stated no he was trying to get cooler and get more air. The report further indicated NA#1 attempted to reposition Resident #1 to slip his head from the opening of the rail but Resident #1 was "minimally cooperative." The report revealed lubricant was applied to Resident's #1's head and the fire department was called for assistance on moving Resident #1 and they arrived and assisted with easy removal of his head from the side rail. The report indicated Nurse #2 assessed Resident #1 for injuries and he had redness to his nose and left cheek. The report also indicated half-length side rails were on Resident #1's bed and immediate actions taken were to provide one on one supervision with a staff member and physician and responsible party (RP) were notified.</p> <p>During an interview on 11/17/17 at 5:11 PM, the MDS Nurse explained she had not coded the side rails as restraints on Resident #1's MDS because there was no place to code side rails on the MDS unless they were used as a restraint. She stated she had not considered the side rails on Resident #1's bed to be a restraint until he got his head stuck in the side rail.</p> <p>During an interview on 11/18/17 at 2:57 PM, the Director of Nursing explained the Administrator had oversight of MDS. She further stated it was her expectation for MDS assessments to be</p>	F 278			

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F 278	<p>Continued From page 28 coded accurately.</p> <p>During an interview on 11/19/17 at 2:43 PM, the Administrator stated it was his expectation MDS assessments to be coded accurately.</p> <p>The Administrator, ADON, Regional Consultant of Clinical Services and Corporate Consultant of Clinical Services were informed of Immediate Jeopardy on 11/18/17 at 11:13 AM.</p> <p>The facility provided an acceptable credible allegation for immediate jeopardy removal on 11/18/17 at 9:54 PM.</p> <p>Credible allegation for Hendersonville Health and Rehabilitation for F278 - Hendersonville Health and Rehab will assure that each resident receives an accurate assessment by a qualified staff member who will assess relevant care areas and have specific knowledge about the resident's status, needs, strengths, and areas of decline. On 11/18/17 Hendersonville Health and Rehab re-evaluated their process to ensure the residents right to an accurate assessment as outlined below.</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;</p> <p>On 11/4/17 Resident #1 was assessed by the licensed admissions nurse using the side rail assessment from the electronic medical record. Following the incident with resident #1 the Director of Clinical Operations updated the side rail evaluation to include the (residents cognitive status, bed mobility status, danger zone status and the proper bed sizing status) to be completed</p>	F 278			

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F 278	<p>Continued From page 29</p> <p>by the licensed nurses upon admission, readmission, significant change in condition and quarterly to ensure a more accurate evaluation of resident safety.</p> <p>The procedure for implementing the acceptable plan of correction for the specific deficiency cited;</p> <p>On 11/18/17 a 100% audit was completed by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. On 11/18/17 a 100% MDS audit was completed by the by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. On 11/18/17 100% MDS nurses were re-educated by the DON/ADON on accurate coding of the MDS assessments according to the RAI manual.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;</p> <ol style="list-style-type: none"> On 11/18/17 a 100% audit was completed by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. On 11/18/17 a 100% MDS audit was completed by the ADON, DON and Regional Clinical Manager to assure accuracy of resident assessments related to side rails. Any negative findings were addressed by the DON, ADON, Unit Manager, maintenance director and environmental services director to assure resident safety. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition by a 	F 278			

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F 278	Continued From page 30 licensed nurse. Identified problems will be addressed by the DON, ADON, Unit Manager, licensed nurse, maintenance director and or environmental services director. 3. On 11/18/17 100% MDS nurses were re-educated by the DON/ADON on accurate coding of the MDS assessments according to the RAI manual. DON and ADON will audit residents MDS assessments for accuracy x 2 weeks. Then 50% will be audited x 2 weeks, then 10% weekly x 4. The results of the audits will be reviewed weekly by the Regional Clinical Manager x 8 weeks to ensure the facility is in compliance with F278. The QA Executive Committee members will then determine the continued need and frequency of audits for F278. The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing and Administrator We certify that as of November 18, 2017 the immediate jeopardy will be removed. Immediate Jeopardy was removed on 11/18/17 when interviews with nurses validated they had received in-service training on side rail assessments on admission, readmission, quarterly and with any significant change in the resident's condition. Interviews with MDS nurses revealed they had also received in-service training regarding accuracy of coding the MDS and accuracy related to side rail assessments.	F 278			
F 279 SS=J	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1)	F 279		1/2/18	

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F 279	<p>Continued From page 31</p> <p>483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its</p>	F 279			

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F 279	<p>Continued From page 32 rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews the facility failed to develop a comprehensive care plan which included side rails as a potential restraint for 1 of 1 sample residents reviewed for physical restraints. Resident #1's head was entrapped in the side rail of his bed and he had to be released from the side rail by fire rescue personnel (Resident #1).</p> <p>Immediate Jeopardy began on 11/06/17 when the facility failed to develop a comprehensive care plan for the use of side rails for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is</p>	F 279	<p>On 11/15/17 at approximately 6:30am resident #1 was found by an employee with his head stuck up to his nose in the side rail. Resident was provided 1:1 supervision until bed could be replaced with a high low bed. The initial side rail assessment was completed on 11/15/17 to ensure resident safety. The revised side rail assessment was completed by the ADON on 11/17/17. The affected resident's bed was replaced with a high/low bed on 11/15/17. The baseline care plan and the 21 day care plan were updated on the affected resident to include securing the upper side rails in the downward position at all times due to entrapment risks on 11/17/17. Resident #1 did not have a care plan that</p>		

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F 279	<p>Continued From page 33 not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 10/17/17 with diagnoses which included septicemia (blood poisoning), difficulty swallowing and acute pyelonephritis (bacterial infection of the kidney).</p> <p>A facility document titled "Initial or Annual Side Rail Assessment" dated 10/18/17 revealed in part the following assessment for Resident #1. The type of side rails on Resident #1's bed were 2 half rails, that Resident #1 was alert, oriented and able to participate appropriately in decision making. The assessment also indicated Resident #1 desired to have his side rails in the raised position, he required total assistance from caregivers and he could not get out of the bed independently. A section labeled Side Rail Conclusions indicated the side rails defined the perimeter of the bed, they did not prevent Resident #1 from getting out of bed while in use and the side rails were not considered a restraint while in use for Resident #1.</p> <p>A review of an admission Minimum Data Set (MDS) dated 10/24/17 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for bed mobility and transfers.</p> <p>An Admission Nursing Evaluation dated 10/25/17, had a section labeled "orientation to facility." The evaluation revealed side rails were indicated for Resident #1.</p>	F 279	<p>addressed the use of side rails.</p> <p>On 11/16/17, the Director of Clinical Operations revised the Corporate Side Rail Assessment. The side rail assessment in the Electronic Medical Record was deactivated on 11/16/17 and will no longer be used by the facility. All residents were assessed by the DON, ADON and Regional Clinical Manger using the revised side rail assessment on 11/17/17. 100% of Baseline care plans, care plans, CNA care guides and MDSs were updated to reflect changes identified using the revised side rail assessment by 11/18/17. Revised side rail assessments will be completed on all residents upon admission, re-admission, quarterly, and with any significant change in the resident's condition as of 11/18/17. MDS completed a 100% audit on 11/18/17 of all MDS assessments for accuracy in regards to proper side rail usage with no discrepancies.</p> <p>All new admissions on or after 11/18/17 will be reviewed by the DON or ADON (100% X two weeks, 50% X 2 weeks and then 10% X two months) to ensure the side rail assessment, 48 hour care plan and the CNA care guide are accurate. MDS RNs will review the side rail assessment and implement the 21 day care plan, quarterly assessment and with any significant change in condition. Any future significant changes will be documented on the care plan and the DON and ADON will review for compliance.</p> <p>The DON, ADON and Regional Clinical Manager were educated by the Director of</p>		

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F 279	<p>Continued From page 34</p> <p>Resident #1 had an unplanned discharge to the hospital on 10/31/17 and was readmitted to the facility on 11/04/17.</p> <p>An Admission Nursing Evaluation dated 11/04/17, had a section labeled "orientation to facility" which indicated Resident #1 was unable to be oriented.</p> <p>A facility document titled "Initial or Annual Side Rail Assessment" dated 11/04/17 revealed in part the following assessment for Resident #1. The type of side rails on Resident #1's bed were 2 quarter rails, that Resident #1 was able to participate appropriately in decision making, had a decreased level of consciousness and desired to have the side rails in the raised position while in bed. The assessment continued to indicate Resident #1 was not able to get out of bed independently and required extensive assistance for bed mobility. A section labeled side rail conclusions indicated the side rails on Resident #1's bed did not define the perimeter of his bed, the side rails did not prevent him from getting out of bed while in use and the side rails were not considered a restraint while in use for Resident #1.</p> <p>A review of a care plan with a problem onset date of 11/06/17 revealed Resident #1 had activities of daily living (ADL) deficits and impaired physical mobility. The goals indicated in part that Resident #1 would remain free from immobility complications and the interventions were listed in part to provide bed mobility and transfers and turn and reposition frequently. There were no interventions documented regarding side rails.</p> <p>Record review revealed a nurse's note</p>	F 279	<p>Clinical Operations related to use of the revised Side Rail Assessment on 11/17/17. This inservice also included care planning and MDS coding of side rail use.</p> <p>MDS RNs were educated on 11/18/17 by the DON on the new side rail assessment, care planning and MDS coding of side rail use.</p> <p>Beginning 11/18/17, DON, ADON or designee will audit 100 % of the resident's side rail assessment, base line care plan and CNA care guide for each admission and or readmission to ensure compliance on going.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	<p>Continued From page 35</p> <p>documented by Nurse #2, and dated 11/15/17 at 6:00 AM. The Nurse's Note indicated Nurse Aide (NA) #1 who was also a Medication Aide reported that Resident #1 had his head through the side rail of his bed and was stuck. The notes revealed that two nurses applied lubrication to his face in an attempt to slide his head out without success. The notes further revealed 911 was called and the fire department and Emergency Medical Services (EMS) was sent to the facility to attempt to free Resident #1's head without injury. The notes indicated Resident #1 was turned in the bed and his head eventually slid out and there was a red mark and indentation on his left cheek from pressure from the side rail but there was no apparent injury.</p> <p>Observation on 11/16/17 at 8:45 AM revealed Resident #1 was in bed with bilateral half rails on the of head of his bed and in the down position.</p> <p>During an interview on 11/17/17 at 3:50 PM, Nurse #4 confirmed she had completed both Side Rail Assessments on 10/18/17 and 11/04/17 and further indicated that on admission Resident #1 was able to grip the side rail to aide in turning and repositioning.</p> <p>During an interview on 11/17/17 at 5:11 PM the MDS Nurse stated she completed MDS assessments and care plans. The MDS Nurse continued to explain she had completed Resident #1's admission assessments. The MDS Nurse indicated she reviewed all information on the resident's chart including hospital information and interviewed the resident and/or the family members when she coded the MDS. The MDS Nurse stated she had observed Resident #1's hand on the side rail and did not believe the side</p>	F 279			

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F 279	<p>Continued From page 36</p> <p>rails would endanger him but she could see now that side rails are not adequate for some residents. The MDS Nurse further stated there was no place to code side rails on the MDS unless they were used as a restraint and this facility was restraint free so they had never put side rails on the care plan.</p> <p>During an interview on 11/18/17 at 2:57 PM, the Director of Nursing (DON) explained Resident #1 leaned significantly toward the left no matter how he was positioned in the bed but he never attempted to get up on his own. If we had any kind of warning signs, interventions would have been in place. I would have expected the side rails to be viewed as a positioning device and not a restraint. The DON explained the facility's practice was to complete a 24 hour interim (initial) care plan until day 21 when the (comprehensive) care plan was completed. The DON stated it was her expectation to complete the side rail information on the care plans after the new Side Rail Evaluation was completed on admission, readmission, quarterly and a change of resident's status.</p> <p>The Administrator, ADON and Regional Consultant of Clinical Services and Corporate Consultant of Clinical Services were informed of Immediate Jeopardy on 11/18/17 at 11:13 AM.</p> <p>The facility provided an acceptable credible allegation for immediate jeopardy removal on 11/18/17 at 7:33 PM.</p> <p>Credible Allegation for Hendersonville Health and Rehabilitation for F279 - Hendersonville Health and Rehab will assure the facility develops and implements a baseline care plan for each</p>	F 279			

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F 279	<p>Continued From page 37</p> <p>resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care. On 11/15/17 Hendersonville Health and Rehab re-evaluated their processes to ensure the residents proper development and implementation of the baseline care plan.</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;</p> <p>Resident #1 did not have a care plan that addressed the use of side rails.</p> <p>" The for implementing the acceptable plan of correction for the specific deficiency cited;</p> <p>On November 18, 2017 DON, ADON and RCM audited all the residents care plans in regards to the proper use of side rails. 100 % of the CNA Care Guides, Interim Care Plans and Care Plans were updated to reflect the usage of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition.</p> <p>In addition MDS completed a 100% of all MDS assessments for accuracy in regards to proper side rail usage with no discrepancies.</p> <p>" The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;</p> <p>Upon admission the DON, ADON will review the 48 hour care plan then will review the working care plan and the 21 day care plan in order to</p>	F 279			

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F 279	Continued From page 38 ensure continued compliance. Any future significant changes will be documented on the care plan and the DON and ADON will review for compliance. The title of the responsible for implementing the acceptable plan of correction. " Director of Nursing and Administrator We certify that as of November 18, 2017 the immediate jeopardy will be removed. Immediately Jeopardy was removed on 11/18/17 when interviews with the nurses and NA's revealed they were inserviced on the resident care plans that had been updated regarding the use of side rails.	F 279			
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		1/2/18	

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F 323	<p>Continued From page 39</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and physician and staff interviews the facility failed to provide a safe environment and maintain safe use of side rails on a resident's bed for a resident (Resident #1) who got his head stuck in the side rail of his bed and his head had to be released from inside the rail by fire rescue personnel in 1 of 81 beds with side rails with openings that had the potential for entrapment out of a total of 130 beds in the facility.</p> <p>Immediate Jeopardy began on 11/15/17 when Resident #1 had his head stuck in the left side rail at the head of his bed and had to be released from inside the side rail by fire department personnel. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on</p>	F 323	<p>On 11/15/17 at approximately 6:30AM resident # 1 (Room 108B) was found by an employee #1. Employee #1, the NA/MA, was working as his medication aide on the 100 hall. She had been working the 7PM to 7AM shift. She was on the 100 hall from 11PM to 7AM. Employee #1 was in room 108 B @ 5:30AM and resident #1 was in the bed with his head elevated at approximately 45 degrees. Employee #1 gave him his morning medications and noted nothing abnormal about the resident. Employee #1 returned to room 108 B at approximately 6:30 AM to check his blood pressure. At that time, Employee #1 noted the top of resident #1's head up to the bridge of his nose was stuck through the side rail on the left side of his bed and his legs were still in the bed. The side rails on both sides of his bed were up. He was on an air mattress. He was talking and answering questions that Employee #1 was asking him. Employee # 1 did not attempt to assist resident #1 at that point. Employee #1 immediately stepped outside the door and asked Employee # 2 (CNA) to get a nurse. Nurse #1, LPN, and Nurse</p>		

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F 323	<p>Continued From page 40</p> <p>10/17/17 with diagnoses which included high blood pressure, septicemia (blood poisoning), difficulty swallowing and acute pyelonephritis (bacterial infection of the kidney).</p> <p>A review of an admission Minimum Data Set (MDS) dated 10/24/17 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for bed mobility and transfers.</p> <p>A facility document titled Initial or Annual Side Rail Assessment dated 10/18/17 indicated Resident #1 had half-rails times (x) 2 sides, was able to participate appropriately in decision making, was not able to get out of bed independently and desired to have side rails in raised position while in bed. The document further indicated Resident #1 was alert and oriented for bed mobility and needed total assistance from care givers. A section labeled Side Rail Conclusions indicated side rails defined the perimeter of the bed, side rails do not prevent resident from getting out of bed, side rails are not considered a restraint, and side rails are not considered a restraint while in use.</p> <p>A review of an Admission Nursing Evaluation dated 10/25/17 in a section labeled orientation to facility indicated side rails were indicated.</p> <p>During an interview on 11/17/17 at 3:56 PM, Nurse #4 explained nurses were expected to complete a nursing admission assessment and a side rail assessment when a resident was admitted. She stated nurses were also expected to complete these assessments again when a resident was readmitted if the resident was out of</p>	F 323	<p>#2 LPN arrived to room 108B within a minute and arrived within seconds of each other. Both assessed the situation and realized the resident had his head up to the bridge of his nose stuck in the side rail. Nurse #1 left the room to get a lubricant. Nurse #1 returned with the lubricant and both nurses began to move his legs off of the bed to line his body up. They worked to free resident #1 from the side rail for approximately 5 minutes. He began to say he was hurting. The nurses stopped and Nurse #2 LPN called 911. EMS arrived at approximately 6:45am. The nursing staff, EMS and the fire department repositioned the resident in the bed and his head freed from the side rail easily. EMS assessed the resident and left the facility. Resident was evaluated by Nurse #2 (LPN). Redness was noted to bridge of the nose and left cheek. Resident #1 remained 1:1 until a new bed arrived.</p> <p>The facility failed to provide a safe environment, will remain free from accents, hazards and that each resident will receive adequate supervision to prevent accidents.</p> <p>Resident #1's medical professional was notified of the incident at 7:00AM on 11/15/17. NP was notified that resident # 1 was 1:1 supervision. She stated a medical professional would be in later on 11/15/17 to assess resident #1. No orders were given. The RP was notified of the incident at 7:15AM on 11/15/17. ADON pulled a facility census and identified all residents' cognitive status to determine appropriateness of side rails.</p>		

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F 323	Continued From page 41 the facility for longer than 24 hours. She confirmed she had completed a nursing admission assessment and a side rail assessment for Resident #1 on 10/18/17 but indicated the date on the nursing admission assessment from the computer system was 10/31/17 and she was not sure why. She explained she had indicated in the section on the admission nursing assessment in a section for orientation to the facility that side rails were indicated for Resident #1 because it was her usual routine to check the side rails box since all resident beds had side rails on them. She further explained she had indicated on the side rail assessment Resident #1 was able to participate appropriately in decision making because he could hold onto the side rail and it was easy for staff to turn him and change him and reposition him because of the side rails on the bed. She stated she thought side rails defined the perimeter of the bed and she thought they were safe. She explained she had indicated Resident #1 desired to have side rails in raised position in bed because that was what she usually put on the assessment. She stated she would consider a side rail to be a restraint when a resident could not get out of bed by themselves. She then confirmed Resident #1 could not get out of bed by himself and stated when he got his head stuck in the side rail then it was a restraint. She stated every resident had side rails on their bed and residents' used them to get in and out of bed. She further stated she had received no training in the facility to determine the length of side rails but based on her nursing experience the side rails that were on Resident #1's bed when he got his head stuck were half-length side rails. She explained Resident #1 was calm at times but at other times he moved and squirmed in bed and	F 323	The ADON then did a facility assessment to determine all residents were safe. MD was in the facility on 11/15/17 at approximately 8:50 AM and assessed the resident. The ADON was in the facility at the time of the incident. The Administrator was notified of the incident by the ADON at 7:13 AM on 11/15/17. The Director of Nursing was notified of the incident by the ADON at 6:40AM on 11/15/17. The Regional Director of Operations was notified by the Administrator of the incident at 7:30 AM on 11/15/17. The Corporate Nursing Team was notified by the Administrator and ADON of the incident by 7:15 AM and a plan of correction was initiated immediately. Resident #1 was placed on one on one supervision and remained one on one until his new bed arrived. He was placed in his new bed at approximately 4:00 pm on 11/15/17. After evaluation of the resident in the new bed it was determined that the side rails would not be secured in the down position. On November 15, 2017 ADON assessed all residents for safe use of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition. Assessment of all residents' safe use of side rails was completed on 11/15/17. An in-service with the nursing department was completed by 11/18/17 by the unit manager and ADON: proper use of side rails related to mental status and not to remove the zip ties (No staff has or will		

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F 323	<p>Continued From page 42</p> <p>there were a few times when she had seen him twisted in bed and she and the NAs had repositioned him.</p> <p>Resident #1 had an unplanned discharge to the hospital on 10/31/17 and was readmitted to the facility on 11/04/17.</p> <p>A review of an Admission Nursing Evaluation dated 11/04/17 indicated in a section labeled orientation to facility Resident #1 was unable to be oriented.</p> <p>A facility document titled Initial or Annual Side Rail Assessment dated 11/04/17 indicated Resident #1 had quarter side rail in use x 2 sides. The assessment further revealed Resident #1 was able to participate appropriately in decision making, was not able to get out of bed independently and desired to have side rails in raised position while in bed. The assessment also revealed Resident #1 had decreased level of consciousness and needed extensive assistance for bed mobility. A section labeled Side Rail Conclusions indicated, side rails do not define the perimeter of the bed, side rails do not prevent resident from getting out of bed, side rails are not considered a restraint, and side rails are not considered a restraint while in use.</p> <p>During an interview on 11/17/17 at 4:37 PM, Nurse #5 confirmed she completed an admission nursing assessment for Resident #1 on 11/04/17 because he had been gone to the hospital for 3 days. She explained she indicated on the admission nursing assessment Resident #1 was unable to be oriented to the facility because when he came back from the hospital he was not as alert as he had been before. She stated nurses</p>	F 323	<p>work until they have received the in-service). All licensed nursing staff that have worked since the in-service will be educated on the updated side rail assessment. 100% of all staff will be in serviced before they return to work. Side rail assessments reviewed with nurses and to be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition.</p> <p>On 11/17/17 100% of all staff prior to assigned shift were in serviced on side rail usage protocol by the dietary manager, therapy manager, administrator, environmental services manager. Side rail management will be added to the general orientation.</p> <p>MDS nursing updated the working plan of care as well as the care plan in chart on all residents that had the side rails secured.</p> <p>All resident care plans were reviewed for appropriate use of side rails and care plans were updated based on results of side rail evaluation. We assessed all residents for safe use of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition.</p> <p>On 11/17/17 Social services, administrative nursing staff and regional clinical manager conducted updated side rail assessments on 100 percent of all residents.</p> <p>Care plans were then updated by DON, ADON and regional clinical manager according to the results of the updated</p>		

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F 323	<p>Continued From page 43</p> <p>were expected to complete a side rail assessment with every nursing admission assessment to determine if the side rail was a restraint. She further stated they did not use half-length side rails in the facility and only used quarter-length side rails because half-length side rails would be considered a restraint. She explained when she completed Resident #1's side rail assessment on 11/04/17 she determined from a mobility standpoint his preferences for side rails. She stated Resident #1 used the side rail to hold on to when staff repositioned him but he could not turn himself in bed. She further stated Resident #1 would wiggle and squirm in bed at times. She confirmed Resident #1 did not say he desired to have the side rails up but he used them as an aid when turning and repositioning. She stated, in regard to bed mobility, Resident #1 was extensive assist with 2 staff and stated she did not think the side rails defined the perimeter of the bed because the side rails did not cover the whole bed since they were only at the top. She further stated she would consider a side rail to be a restraint when a resident would not be able to get out of bed or the side rail was blocking their exit. She then verified Resident #1 was not able to get out of bed by himself but she had not considered the side rail on Resident #1's bed as a restraint. She stated every bed in the facility had side rails on them and there were different types of beds and side rails.</p> <p>A review of a care plan with a problem onset date of 11/06/17 revealed Resident #1 had activities of daily living (ADL) deficits and impaired physical mobility. The goals indicated in part Resident #1 would remain free from immobility complications and the interventions were listed in part to provide</p>	F 323	<p>side rail assessment.</p> <p>Maintenance director completed a 100% audit of all residents for the proper bed dimension due to size and weight. Maintenance director also completed an audit of all residents for the risk of entrapment from use of side rails. Notification of updated side rail usage protocol will be mailed to the resident and or resident representative by 11/18/17. All residents were re-assessed by licensed staff using the updated side rail assessment on 11/17/17. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition. Notification of updated side rail usage protocol was mailed to the resident and or resident representative on 11/18/17. Side rail assessments will be completed by licensed nurses upon admission, re-admission, quarterly, and with any significant change in the resident's condition. The updated side rail assessment will be used. The maintenance director will conduct/zone safety assessments daily for two weeks (100%), weekly for two weeks (50%) and then monthly for 2 months (10%) and then quarterly (100%) to ensure residents safety. The results will be reviewed by the Administrator weekly x 4 then monthly x 2. The Executive QA committee will review the results monthly for 3 months to determine continued frequency and need for monitoring.</p>		

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F 323	<p>Continued From page 44</p> <p>bed mobility and transfers and turn and reposition frequently. There were no interventions documented regarding side rails.</p> <p>A review of a nurse's note documented by Nurse #2 indicated on 11/15/17 at 6:00 AM revealed Nurse Aide (NA) #1 who was also a Medication Aide reported that Resident #1 had his head through the side rail of his bed and was stuck. The notes indicated nurses x 2 applied lubrication to his face in an attempt to slide his head out without success. The notes further indicated 911 was called and the fire department and Emergency Medical Services (EMS) was sent to the facility to attempt to free Resident #1's head without injury. The notes further revealed Resident #1 was turned in the bed and his head eventually slid out and there was a red mark and indentation on his left cheek from pressure from the side rail but there was no apparent injury.</p> <p>A review of an incident report dated 11/15/17 at 6:30 AM completed by the Assistant Director of Nursing (ADON) revealed NA #1 entered Resident #1's room to check his blood pressure and Resident #1 was observed with the top of his head in the upper side rail. The report indicated when Resident #1 was asked what he was doing, he replied he was trying to break his neck, then stated no he was trying to get cooler and get more air. The report further indicated NA#1 attempted to reposition Resident #1 to slip his head from the opening of the rail but Resident #1 was "minimally cooperative." The report revealed lubricant was applied to Resident's #1's head and the fire department was called for assistance on moving Resident #1 and they arrived and assisted with easy removal of his head from the side rail. The report indicated Nurse #2 assessed</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>Resident #1 for injuries and he had redness to his nose and left cheek. The report also indicated half-length side rails were on Resident #1's bed and immediate actions taken were to provide one on one supervision with a staff member and physician and responsible party (RP) were notified.</p> <p>A review of a Fire and Rescue Report dated 11/15/17 at 7:17 AM indicated 2 rescue personnel responded to a call from the facility and Resident #1 had his head stuck in a side rail. The report further indicated rescue personnel had nurses rotate Resident #1's body while they pushed his head toward the mattress in order to free him. The report also indicated there were no injuries or complaints of pain by Resident #1 after his head was released from the side rail.</p> <p>During a telephone interview on 11/16/17 at 4:05 PM, NA#1 who was also a Medication Aide stated she took medications to Resident #1 on 11/15/17 at 5:30 AM and he was fine. She explained she went back into Resident #1's room to take his blood pressure at 6:30 AM and found him lying across the bed with his head in the left side rail and his legs were off the right side of the bed. She stated she asked him what he was doing to get into that position and he said he was trying to break his neck then said he was trying to get some air. She stated he had a nasal cannula with oxygen on and had an air mattress on his bed which was inflated. She explained she called for Nurse Aides (NAs) #2 and #6 to help and then NA#2 went to get Nurse #1 and Nurse #2. She stated the nurses went and got lubricant and rubbed it on Resident #1's head to try to slide his head out but he wasn't tolerating that well so they stopped and called the fire department and they</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>were able to get Resident #1 repositioned and got his head out of the side rail. She further stated the left side of Resident #1's face was red from the pressure from the bed rail.</p> <p>During a follow up interview on 11/17/17 at 9:12 AM, NA #1 clarified Resident #1 came back to the facility from the hospital at 1:08 AM on 11/15/17 and his blood pressure was high so she was keeping a check on it about every hour. She stated each time she went in his room he was on his back and the head of his bed was elevated approximately 45 degrees and both side rails were raised up at the head of his bed. She explained at 5:30 AM she took his morning meds to him and he was fine and the head of the bed was still up at approximately 45 degrees. She stated at approximately 6:30 AM she went back to check Resident #1's blood pressure and found Resident #1 with his head stuck in the left side rail from the back of his head to the bridge of his nose. She explained Resident #1 did not seem to be in distress and was calm but his head seemed to be really stuck. She further explained when Nurse #1 and Nurse #2 were putting lubricant on Resident #1's head and face Resident #1 put his hands on the bed rail and was pulling himself further into the opening of the side rail and they told him to stop pulling on the rail. She stated she and NA #6 were holding Resident #1's legs because they were hanging off the side of the bed and when the fire department and EMS got there they said they had cutters and were going to cut the side rail but when they pulled Resident #1's legs toward the head of the bed and he was straight across the mattress then his head came out of the side rail. She further stated side rails were common in the facility and as far as she knew, every resident had side rails on their bed.</p>	F 323			

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F 323	Continued From page 47 During an interview on 11/17/17 at 6:45 AM, NA #2 stated she worked the night shift on 11/15/17 and made rounds around 5:20 AM with NA #6 and checked on Resident #1 and at that time Resident #1 was asleep with oxygen on. She further stated she did not know anything had happened until NA#1 told her to get a nurse. She explained NA #1 stayed with Resident #1 and NA #2 told Nurse #1 to go to Resident #1's room. She stated after Nurse #1 went into Resident #1's room she then went to get lubricant and Nurse #1 told her to go get the ADON. NA #2 further stated Resident #1 said he was trying to get fresh air but she did not know how he could have gotten his head stuck in the side rail. During an interview on 11/17/17 at 7:05 AM, NA #6 stated on 11/15/17 she assisted NA #2 and they had checked Resident #1 during their last round around 5:20 AM and he was lying on his left side. She explained later she was coming off her assigned hall when NA #1 motioned for her to come to Resident #1's room. She explained when she got to Resident #1's room he had his head caught in the left side rail. She stated Resident #1 said he was looking for fresh air and they tried to get his head out with lubricant but his head wouldn't budge. She explained they called the fire department and EMS and they came and got his head out and Resident #1 had an indentation on the left side of his face from the side rail. During an interview on 11/17/17 at 7:15 AM, Nurse #1 stated on 11/15/17 she walked to a medication room and NA #2 came in and told her NA#1 needed her help in Resident #1's room. She explained she walked into Resident #1's	F 323			

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F 323	<p>Continued From page 48</p> <p>room and he was lying on his left side with his head stuck inside the side rail. She stated she asked Resident #1 why his head was stuck in the side rail and he said it is cooler on the other side. She explained she told Resident #1 she was going to get some stuff to lubricate his head and free him and then she met Nurse #2 and took her to Resident #1's room and they put the lubricant on his head but it didn't work to get his head out of the side rail. She stated she told someone but could not remember who to go get the ADON and she came in Resident #1's room and they decided to call the fire department and EMS. She explained the only time Resident #1 said anything was when they tried to move him and he said it hurt and his face started to swell.</p> <p>During an interview on 11/16/17 at 11:17 AM, Nurse #2 explained she worked third shift on 11/15/17 and a NA signaled for her to come to Resident #1's room. She stated she could not recall which NA called to her but as she walked by the nurse's station Nurse #1 was coming out of the medication room with a box of lubricant and stated she was going to Resident #1's room. She explained when she entered Resident #1's room he was on his back but leaning toward his left side and his head was stuck in the open part of the left side rail. She stated Resident #1 wasn't talking much but she and Nurse #1 applied lubricant to Resident #1's face and tried to pull him out but it didn't work. She explained NA #2 went to get the ADON to come to Resident #1's room. She stated she thought if they turned Resident #1's body in alignment with his head they could slide him out but that didn't work. She explained he ADON said they should call the fire department and Nurse #2 called 911 and explained the problem and the dispatcher said</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>they would send the fire department and EMS. She stated when the fire department and EMS arrived they turned Resident #1's body to be across the bed and the rescue personnel pushed Resident #1's head back through the rail and his head slid out. She explained Resident #1 had an indentation and a red mark from the side rail on his left cheek but there was no broken skin. She stated she did not know how he got his head stuck in the rail.</p> <p>During an interview on 11/16/17 at 12:09 PM, the ADON explained NA #2 came and got her around 6:30 AM on 11/15/17 and told her to come to Resident #1's room. She stated when she entered Resident #1's room, he was lying sideways in the bed with his upper body toward the left side of the bed and his head was in the left side rail up to the bridge of his nose and his left cheek was pressed into the rail. She explained Resident #1 was groaning and someone had put lubricant on his face and forehead to try to slide his head out but it didn't help. She stated Nurse #2 called 911 and the fire department and EMS came but she wasn't in the room when they got his head out of the side rail. She explained she called the Nurse Practitioner (NP) and was told a physician would be at the facility later that day to see Resident #1. She stated the NP also stated she would talk with the Medical Director to let him know but to continue to provide Resident #1 with one-on-one supervision. The ADON stated she then called Resident #1's RP.</p> <p>During an interview on 11/16/17 at 1:30 PM, Nurse #6 stated she arrived at work on 11/15/17 at 6:45 AM and staff were in Resident #1's room waiting for the fire department and EMS. She</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 50</p> <p>explained Resident #1 normally slept a lot during the day but sometimes during the evening he had a tendency to be restless. She stated she had noticed twice lately Resident #1 had his legs thrown over the side of the bed. She stated she asked him why he was restless but he couldn't tell her.</p> <p>During an interview on 11/16/17 at 3:00 PM, NA #3 stated she was told yesterday morning on 11/15/17 around 7:00 AM during report from third shift Resident #1 had his head stuck into the side rail. She explained the left side of his face was a little red yesterday but there was no redness today. She stated she was surprised Resident #1 had his head stuck in the side rail because she had not seen him try to get out of bed.</p> <p>During an interview and observation on 11/16/17 at 1:05 PM, the Environmental Services (EVS) Director stated he was notified about 7:30 AM on 11/15/17 by the ADON that Resident #1 needed a Hi-Low bed because they had a problem with the side rails on his current bed. He stated he went to Resident #1's room and placed zip ties to secure the side rails to the frame of the bed so they could not be pulled back up and then he called the company to order a Hi-Lo bed. He stated the new bed was delivered around 3:45 PM on 11/15/17 and he took the old bed to a service hall with the side rails still attached to the bed. The EVS Director pointed to a bed in the service hallway and confirmed it was the bed he had removed from Resident #1's room. He then raised the left side rail of the bed and measured the diameter of the 2 largest openings of the side rail. He confirmed both of the large openings were 7.5 inches wide X 7.0 inches high.</p>	F 323			

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F 323	<p>Continued From page 51</p> <p>During an interview on 11/16/17 at 2:10 PM, Physician #1 who was also the facility Medical Director stated a NP had called him yesterday morning on 11/15/17 and told him Resident #1 made the statement about wanting to break his neck and asked if we should send him for psychiatric services. He stated Physician #2 saw Resident #1 on 11/15/17 and did not think Resident #1 was a risk to himself. Physician #1 stated he thought Resident #1 had dementia but did not think he was suicidal.</p> <p>During an observation on 11/16/17 at 5:11 PM Resident #1 was sitting up in bed and had no visible red areas or bruises on his face.</p> <p>During an interview on 11/16/17 at 5:40 PM, NA #4 stated Resident #1 was usually confused when she was assigned to his care and he needed total assistance with activities of daily living. She further stated Resident #1 could scoot down in the bed.</p> <p>During an interview on 11/16/17 at 5:55 PM, NA #5 stated she had provided care to Resident #1 and in the past she had seen him with his legs off the left side of the bed and she had to go and reposition him.</p> <p>During an observation on 11/17/17 at 8:05 AM Resident #1 was lying in bed and NA #3 was on the right side of his bed. Resident #1 had his eyes closed and there were no red areas or bruised visible on his face or neck.</p> <p>During a follow up interview on 11/17/17 at 8:29 AM, the EVS Director explained the type of bed Resident #1 had his head caught in the side rail were old beds from a local hospital that were put</p>	F 323			

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F 323	<p>Continued From page 52</p> <p>in the facility years ago. He stated over the years they had purchased some Hi-Low beds and they had side rails with spaces that were much smaller than the old bed side rails. He stated all beds in the facility had side rails on them because beds came delivered with side rails already on them. He explained they had taken the rails off the beds at the foot because if they had rails at the top and foot they would be restraints. He stated he thought the side rail on the bed that Resident #1's head was stuck in was a quarter-length side rail. He stated there were 130 beds in the facility but he did not have an inventory list of the type of side rails on each bed.</p> <p>During an interview on 11/17/17 at 5:11 PM, the MDS Nurse confirmed she had completed Resident #1's MDS assessment. She stated there was no place to code side rails on the MDS unless they were used as a restraint. She further stated side rails were not listed on Resident #1's care plan because they were not considered restraints. She explained the facility was restraint free and they had never put side rails on a care plan but now she could see side rails were not adequate for some residents. She stated she visited with Resident #1 after he got his head stuck in the side rail and asked him what had happened and he said he was trying to get out there and get some more air but he was not trying to get out of bed. She explained when she had visited with him in the past and he was lying on his side he had his hand resting on top of the side rail. She stated she would not have anticipated the side rail on his bed would have endangered Resident #1. She stated she thought most of the beds in the facility had side rails on them but they did not use half-length side rails. She further stated it was her understanding that side rail</p>	F 323			

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F 323	<p>Continued From page 53</p> <p>assessments were done to determine if the resident wanted the side rails up or down and Resident #1 could answer simple questions but if the questions was complex he had trouble answering them.</p> <p>During an interview on 11/17/17 at 5:39 PM, the Maintenance Director stated every bed in the facility had quarter-length side rails and he thought the side rails were on the beds because that was the way they were delivered. He explained he did maintenance on beds if they squeaked or the brakes didn't work or if the side rails were loose. He confirmed most of the beds in the facility were beds like the one Resident #1 got his head caught in the side rail. He stated newer beds had more compact openings with less space in the openings. He further stated he had not received any work order requests for Resident #1's bed or side rails. He explained the type of bed Resident #1 was in when his head was stuck in the side rail was an older hospital bed manufactured before 1997 because he had found inspection stickers on them from a local hospital dated 1997 and he had ordered replacement parts for the beds that were dated 1996 and 1997.</p> <p>During a follow up interview on 11/17/17 at 5:55 PM, the ADON stated every bed in the facility had quarter-length side rails but if a resident did not want side rails they took them off. She explained a side rail assessment was completed by the nurse when a resident was admitted or readmitted to the facility and the side rail assessment was supposed to determine how the resident used side rails and if the side rails restricted their movements. She stated she knew when Resident #1's head was caught in the side</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>rail it was a problem and if it happened to him it could happen to another resident.</p> <p>During a record review on 11/18/17 at 9:45 AM a service manual for a resident bed revealed the bed was configured to accept sectionalized half-length side rails. The manual further indicated the bed must have the head section side rails because both head section rails contained head and knee controls and hi-low activators to raise the bed up or down.</p> <p>During a follow up interview on 11/18/17 at 10:15 AM, the EVS Director confirmed the service manual for a resident bed was for the same type bed Resident #1 was in when he got his head stuck in the side rail. He also provided a bed audit he had completed on 11/17/17 of all beds in the facility and explained there were 81 beds which were the same type as the bed Resident #1 got his head stuck in the side rail, 33 Hi-Low beds the facility owned, 15 rental beds and 1 personal bed to equal 130 beds in the facility.</p> <p>During an interview on 11/18/17 at 2:57 PM, the Director of Nursing stated she was on vacation earlier in the week but was called by the ADON after Resident #1 got his head stuck in the side rail and she came back to the facility. She further stated she had not considered the side rails on Resident #1's bed to be quarter-length rails but after review of the service manual for the bed she now realized they were half-length side rails. She explained the older beds like the one Resident #1 got his head stuck in the side rail came when the facility was opened years ago. She stated Resident #1 leaned significantly toward his left side regardless of how he was positioned and if his body was in the direction of the side rail with</p>	F 323			

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F 323	<p>Continued From page 55</p> <p>his head near the rail that would have been a red flag. She stated it was her expectation for staff to look and see if the side rail was a positioning device and should not restrict movement of the resident.</p> <p>During an interview on 11/18/17 at 4:05 PM, Physician #1 who was also the facility Medical Director stated he was notified promptly when Resident #1 got his head caught in the side rail. He further stated the incident was left over to 20 years with use of beds with older side rail designs.</p> <p>During an interview on 11/19/17 at 2:43 PM, the Administrator stated it was his expectation that any kind of equipment needed to be looked at for potential for harm. He stated when he came to work at the facility earlier this year he did not think to look at the assessments of beds or side rails. He stated it was his expectation staff could not let their guard down but needed to protect residents from harm.</p> <p>The Administrator, ADON, Regional Consultant of Clinical Services and Corporate Consultant of Clinical Services were informed of Immediate Jeopardy on 11/17/17 at 2:33 PM.</p> <p>The facility provided an acceptable credible allegation for immediate jeopardy removal on 11/18/17 at 4:58 PM.</p> <p>Credible Allegation for Hendersonville Health and Rehabilitation for F 323- HHR will ensure that the resident's environment will remain free from accident hazards and that each resident will receive adequate supervision to prevent accidents. On 11/15/17 Hendersonville Health</p>	F 323			

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F 323	<p>Continued From page 56</p> <p>and Rehab re-evaluated their processes to ensure that the resident's environment will remain free from accident hazards and that each resident will receive adequate supervision to prevent accidents as outlined below.</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;</p> <p>On 11/15/17 at approximately 6:30AM resident # 1 (Room 108 B) was found by an employee #1. Employee #1, the NA/MA, was working as his medication aide on the 100 hall. She had been working the 7 PM to 7 AM shift. She was on the 100 hall from 7 PM to 7 AM. Employee #1 was in room 108 B @ 5:30 AM and resident #1 was in the bed with his head elevated at approximately 45 degrees. Employee #1 gave him his morning medications and noted nothing abnormal about the resident. Employee #1 returned to room 108 B at approximately 6:30 AM to check his blood pressure. At that time, Employee #1 noted the top of resident #1's head up to the bridge of his nose was stuck through the side rail on the left side of his bed and his legs were still in the bed. The side rails on both sides of his bed were up. He was on an air mattress. He was talking and answering questions that Employee #1 was asking him. Employee #1 did not attempt to assist resident #1 at that point. Employee #1 immediately stepped outside the door and asked Employee #2 (CNA) to get a nurse. Nurse #1, LPN, and Nurse #2 LPN arrived to room 108 B within a minute and arrived within seconds of each other. Both assessed the situation and realized the resident had his head up to the bridge of his nose stuck in the side rail. Nurse #1 left the room to get a lubricant. Nurse #1</p>	F 323			

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F 323	<p>Continued From page 57</p> <p>returned with the lubricant and both nurses began to move his legs off of the bed to line his body up. They worked to free resident #1 from the side rail for approximately 5 minutes. He began to say he was hurting. The nurses stopped and Nurse #2 LPN called 911.</p> <p>EMS arrived at approximately 6:45 AM. The nursing staff, EMS and the fire department repositioned the resident in the bed and his head freed from the side rail easily. EMS assessed the resident and left the facility. Resident was evaluated by Nurse #2 (LPN). Redness was noted to bridge of the nose and left cheek. Resident #1 remained 1:1 until a new bed arrived.</p> <p>Resident #1's medical professional was notified of the incident at 7:00 AM on 11/15/17. NP was notified that resident #1 was one on one supervision. She stated a medical professional would be in later on 11/15/17 to assess resident #1. No orders were given. The RP was notified of the incident at 7:15 AM on 11/15/17. ADON pulled a facility census and identified all residents' cognitive status to determine appropriateness of side rails. The ADON then did a facility assessment to determine all residents were safe. MD was in the facility on 11/15/17 at approximately 8:50 AM and assessed the resident.</p> <p>The ADON was in the facility at the time of the incident. The Administrator was notified of the incident by the ADON at 7:13 AM on 11/15/17. The Director of Nursing was notified of the incident by the ADON at 6:40 AM on 11/15/17. The Regional Director of Operations was notified by the Administrator of the incident at 7:30 AM on 11/15/17.</p>	F 323			

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F 323	Continued From page 58 The Corporate Nursing Team was notified by the Administrator and ADON of the incident by 7:15 AM and a plan of correction was initiated immediately. o The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Resident #1 was placed on one on one supervision and remained one on one until his new bed arrived. He was placed in his new bed at approximately 4:00 PM on 11/15/17. After evaluation of the resident in the new bed it was determined that the side rails would not be secured in the down position. Brief Interviews for Mental Status (BIM's) scores for all residents were pulled from our electronic medical record (EMR). On November 15, 2017 we assessed all residents for safe use of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition. An in-service with the nursing department was done by the unit manager and ADON: proper use of side rails related to mental status and not to remove the zip ties (No staff has or will work until they have received the in-service). All licensed nursing staff that have worked since the in-service will be educated on the updated side rail assessment. 100% of all staff will be in serviced before they return to work. Side rail assessments reviewed with nurses and to be completed upon admission, re-admission, quarterly, and with any significant change in the	F 323			

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F 323	<p>Continued From page 59 resident's condition.</p> <p>On 11/17/17 100% of all staff prior to assigned shift were in serviced on side rail usage protocol by the dietary manager, therapy manager, administrator, environmental services manager. Side rail management will be added to the general orientation.</p> <p>MDS nursing updated the working plan of care as well as the care plan in chart on all residents that had the side rails secured.</p> <p>All resident care plans were reviewed for appropriate use of side rails and care plans were updated based on results of side rail evaluation. We assessed all residents for safe use of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition.</p> <p>On 11/17/17 Social services, administrative nursing staff and regional clinical manager conducted updated side rail assessments on 100 percent of all residents.</p> <p>Care plans were then updated by DON, ADON and regional clinical manager according to the results of the updated side rail assessment.</p> <p>Maintenance director completed a 100% audit of all residents for the proper bed dimension due to size and weight. Maintenance director also completed an audit of all residents for the risk of entrapment from use of side rails.</p> <p>Notification of updated side rail usage protocol will be mailed to the resident and or resident representative by 11/18/17.</p>	F 323			

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F 323	<p>Continued From page 60</p> <p>o The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.</p> <ol style="list-style-type: none"> We assessed all residents for safe use of side rails. Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition. <p>o The title of the person responsible for implementing the acceptable plan of correction.</p> <p>" Director of Nursing and Administrator</p> <p>We certify that as of November 18, 2017 the immediate jeopardy will be removed.</p> <p>Immediate Jeopardy was removed on 11/18/17 when interviews with nurses and NA's validated they were aware of proper use of side rails related to a resident's mental status and use of new side rail assessments and side rail management has been added to general orientation. They also confirmed they had been in-serviced on the side rail usage protocol and resident care plans had been updated regarding use of side rails. Administrative staff were also interviewed and stated they had been in-serviced on side rail assessments and new assessments had been completed for every resident in the facility. They stated they were aware they were to report any concerns regarding side rails on resident beds to Administration immediately. Confirmation was provided by Administration that the updated side rail usage protocol had been mailed to residents or their representatives. An</p>	F 323			

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F 323	Continued From page 61 interview with the EVS Director and Maintenance Director confirmed they had received in-service education and had audited 100% of resident beds for the risk of entrapment from side rails.	F 323			
F 461 SS=E	BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET CFR(s): Various sections in 483.10,483.25,483.90 483.10 (i)(4) Private closet space in each resident room, as specified in §483.90(e)(2)(iv); 483.25 (n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. 483.90 (c)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. (e)(1)(vi) - Resident Rooms Bedrooms must -- (vi) - Have at least one window to the outside; and (vii) Have a floor at or above grade level. (e)(2) -The facility must provide each resident with--	F 461		1/2/18	

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F 461	<p>Continued From page 62</p> <p>(i) A separate bed of proper size and height for the safety and convenience of the resident;</p> <p>(ii) A clean, comfortable mattress;</p> <p>(iii) Bedding, appropriate to the weather and climate; and</p> <p>(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews the facility failed to conduct regular inspection of all bed frames, mattresses and bed rails as a part of a regular maintenance program and a resident (Resident #1) got his head stuck in the side rail of his bed and his head had to be released from inside the rail by fire rescue personnel in 1 of 81 beds with side rails with openings that had the potential for entrapment out of a total of 130 beds in the facility.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 10/17/17 with diagnoses which included high blood pressure, septicemia (blood poisoning), difficulty swallowing and acute pyelonephritis (bacterial infection of the kidney).</p> <p>A review of an admission Minimum Data Set (MDS) dated 10/24/17 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for bed mobility and transfers.</p>	F 461	<p>On 11/15/17 at approximately 6:30am resident #1 was found by an employee with his head stuck up to his nose in the side rail. Resident was provided 1:1 supervision until bed could be replaced with a high low bed. Upon arrival of the replacement high/low bed the Maintenance director assessed the bed to ensure that the bed rails, mattress and bed frame were compatible. A new side rail assessment was completed by the ADON on 11/15/17. On 11/17/17 a revised side rail assessment was completed by the ADON on the affected resident. The residents side rails were secured in the down position and care planned. The facility failed to meet the standard practice by not completing regular inspections of all bed frames, mattress and bed rails as part of a regular maintenance program.</p> <p>On 11/18/17 100% audit was conducted by the regional clinical nurse and Director of clinical operations on all beds for entrapment potential related to mattresses</p>		

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F 461	Continued From page 63 A review of a nurse's note documented by Nurse #2 indicated on 11/15/17 at 6:00 AM indicated Nurse Aide (NA) #1 who was also a Medication Aide reported that Resident #1 had his head through the side rail of his bed and was stuck. The notes revealed nurses x 2 applied lubrication to his face in an attempt to slide his head out without success. The notes further revealed 911 was called and the fire department and Emergency Medical Services (EMS) was sent to the facility to attempt to free Resident #1's head without injury. The notes indicated Resident #1 was turned in the bed and his head eventually slid out and there was a red mark and indentation on his left cheek from pressure from the side rail but there was no apparent injury. A review of an incident report dated 11/15/17 at 6:30 AM completed by the Assistant Director of Nursing (ADON) revealed NA #1 entered Resident #1's room to check his blood pressure and Resident #1 was observed with the top of his head in the upper side rail. The report indicated when Resident #1 was asked what he was doing, he replied he was trying to break his neck, then stated no he was trying to get cooler and get more air. The report further indicated NA #1 attempted to reposition Resident #1 to slip his head from the opening of the rail but Resident #1 was "minimally cooperative." The report revealed lubricant was applied to Resident's #1's head and the fire department was called for assistance on moving Resident #1 and they arrived and assisted with easy removal of his head from the side rail. The report indicated Nurse #2 assessed Resident #1 for injuries and he had redness to his nose and left cheek. The report also indicated half-length side rails were on Resident #1's bed	F 461	and side rails. All identified areas of concerns were addressed to ensure resident safety. On November 18, 2017 the regional clinical nurse did an in-service for the maintenance director and environmental service director on how to determine if a mattress fits and is not an entrapment issue. Bed assessments will be completed by licensed nurses upon admission, re-admission, quarterly, and with any significant change in the resident's condition. The updated side rail assessment will be used. The maintenance director will conduct/zone safety assessments daily for two weeks (100%), weekly for two weeks (50%) and then monthly for 2 months (10%) and then quarterly (100%) to ensure residents safety. The results will be reviewed by the Administrator weekly x 4 then monthly x 2. The QA executive committee will review monthly x 3 and then quarterly to ensure zone safety assessments are performed to ensure resident safety.		

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F 461	<p>Continued From page 64</p> <p>and immediate actions taken were to provide one on one supervision with a staff member and physician and responsible party (RP) were notified.</p> <p>A review of a Fire and Rescue Report dated 11/15/17 at 7:17 AM indicated 2 rescue personnel responded to a call from the facility and Resident #1 had his head stuck in a side rail. The report further indicated rescue personnel had nurses rotate Resident #1's body while they pushed his head toward the mattress in order to free him. The report also indicated there were no injuries or complaints of pain by Resident #1 after his head was released from the side rail.</p> <p>During an interview on 11/16/17 at 1:05 PM, the Environmental Services (EVS) Director stated he was notified about 7:30 AM on 11/15/17 by the ADON that Resident #1 needed a Hi-Low bed because they had a problem with the side rails on his current bed. He stated a new bed was delivered around 3:45 PM on 11/15/17 and he took the old bed to a service hall with the side rails still attached to the bed. The EVS Director confirmed measurements he had taken of the diameter of the 2 largest openings of the side rail were 7.5 inches wide X 7.0 inches high.</p> <p>During a follow up interview on 11/17/17 at 8:29 AM, the EVS Director explained the type of bed Resident #1 had his head caught in the side rail were old beds from a local hospital that were put in the facility years ago. He stated all beds in the facility had side rails on them because beds came delivered with side rails already on them. He further stated he thought the side rail on the bed that Resident #1's head was stuck in was a quarter-length side rail but he did not have an</p>	F 461			

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F 461	<p>Continued From page 65</p> <p>inventory list of the type of side rails on each bed. He stated maintenance staff repaired beds when a problem was reported but he was not aware of any routine inspections of beds or side rails.</p> <p>During an interview on 11/17/17 at 5:39 PM, the Maintenance Director stated every bed in the facility had quarter-length side rails and he thought the side rails were on the beds because that was the way they were delivered. He explained he did maintenance on beds if they squeaked or the brakes didn't work or if the side rails were loose but he did not conduct a regular inspection of beds, mattresses or side rails and was not aware he was supposed to. He confirmed most of the beds in the facility were beds like the one Resident #1 got his head caught in the side rail. He stated newer beds had more compact openings with less space in the openings. He further stated he had not received any work order requests for Resident #1's bed or side rails. He explained the type of bed Resident #1 was in when his head was stuck in the side rail was an older hospital bed manufactured before 1997 because he had found inspection stickers on them from a local hospital dated 1997 and he had ordered replacement parts for the beds that were dated 1996 and 1997.</p> <p>During a follow up interview on 11/18/17 at 10:15 AM, the EVS Director provided a bed audit he had completed on 11/17/17 of all beds in the facility and explained there were 81 beds which were the same type as the bed Resident #1 got his head stuck in the side rail, 33 Hi-Low beds the facility owned, 15 rental beds and 1 personal bed to equal 130 beds in the facility.</p> <p>During an interview on 11/18/17 at 2:57 PM, the</p>	F 461			

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F 461	Continued From page 66 Director of Nursing stated she recalled in April 2017 they had received an email from their Corporate Nurse Consultant regarding changes to regulations and requirements to do audits of beds and side rails. She explained an audit was done after the email was received and they looked at the whole bed and checked to make sure mattresses fit properly but the audit was not documented. She stated she was not aware any audits of beds or side rails had been done since that time. She further stated it was her expectation for staff to look and see if the side rail was a positioning device and it should not restrict movement of the resident. She explained they had discussed replacing beds on the rehabilitation halls but the cost of replacing beds was very expensive and they knew new beds would have to be budgeted. During an interview on 11/19/17 at 2:43 PM, the Administrator stated it was his expectation that any kind of equipment needed to be looked at for the potential for harm. He stated he was aware of the regulation to conduct regular inspections of beds, mattresses and side rails but when he came to work at the facility earlier this year he did not think to look at the assessments of beds or side rails because at his previous facility someone had taken care of that for him.	F 461			
F 490 SS=J	EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING CFR(s): 483.70 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 490		1/2/18	

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F 490	<p>Continued From page 67</p> <p>well-being of each resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews the facility administration failed to administer a safe, systemic approach with the use of side rails and failed to conduct regular inspection of all bed frames, mattresses and bed rails as a part of a regular maintenance program when a resident (Resident #1) got his head stuck in the side rail of his bed and his head had to be released from inside the rail by fire rescue personnel in 1 of 81 beds with side rails with openings that had the potential for entrapment out of a total of 130 beds in the facility.</p> <p>Immediate Jeopardy began on 10/24/17 when on the admission MDS side rails were not coded as a restraint for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of E (Pattern with no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>1. Cross refer to F 221: Based on observations, record review and physician and staff interviews the facility failed to provide an environment free from restraints when a resident (Resident #1) got his head stuck in the side rail of his bed and his head had to be released from inside the side rail by fire rescue personnel in 1 of 81 beds with side rails with openings that had the potential for</p>	F 490	<p>On 11/15/17 at approximately 6:30AM resident # 1 (Room 108B) was found by an employee #1. Employee #1, the NA/MA was working as his medication aide on the 100 hall. She had been working the 7PM to 7AM shift. She was on the 100 hall from 11PM to 7AM. Employee #1 was in room 108 B @ 5:30AM and resident #1 was in the bed with his head elevated at approximately 45 degrees. Employee #1 gave him his morning medications and noted nothing abnormal about the resident. Employee #1 returned to room 108 B at approximately 6:30 AM to check his blood pressure. At that time, Employee #1 noted the top of resident #1's head up to the bridge of his nose was stuck through the side rail on the left side of his bed and his legs were still in the bed. The side rails on both sides of his bed were up. He was on an air mattress. He was talking and answering questions that Employee #1 was asking him. Employee # 1 did not attempt to assist resident #1 at that point. Employee #1 immediately stepped outside the door and asked Employee # 2 (CNA) to get a nurse. Nurse #1, LPN, and Nurse #2 LPN arrived to room 108B within a minute and arrived within seconds of each other. Both assessed the situation and realized the resident had his head up to the bridge of his nose stuck in the side rail. Nurse #1 left the room to get a lubricant. Nurse #1 returned with the lubricant and both nurses began to move</p>		

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F 490	<p>Continued From page 68</p> <p>entrapment out of a total of 130 beds in the facility.</p> <p>2. Cross refer to F 278: Based on record reviews and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) of a resident for use of side rails as a potential restraint. The resident (Resident #1) got his head stuck in the side rail of his bed and his head had to be released from inside the side rail by fire rescue personnel for 1 of 4 sampled residents who had side rails on their beds.</p> <p>3. Cross refer to F 279: Based on observations, record review and staff interviews the facility failed to develop a comprehensive care plan which included side rails as a potential restraint for 1 of 1 sample residents reviewed for physical restraints. Resident #1's head was entrapped in the side rail of his bed and he had to be released from the side rail by fire rescue personnel (Resident #1).</p> <p>4. Cross refer to F 323: Based on observations, record review and physician and staff interviews the facility failed to provide a safe environment and maintain safe use of side rails on a resident's bed for a resident (Resident #1) who got his head stuck in the side rail of his bed and his head had to be released from inside the rail by fire rescue personnel in 1 of 81 beds with side rails with openings that had the potential for entrapment out of a total of 130 beds in the facility.</p> <p>During an interview with the Administrator on 11/19/17 at 2:43 PM he stated he felt the facility had to be more proactive instead of reactive to make sure equipment for residents was safe. He further stated they could not let their guard down</p>	F 490	<p>his legs to line his body up. They worked to free resident #1 from the side rail for approximately 5 minutes. He began to say he was hurting. The nurses stopped and Nurse #2 LPN called 911.</p> <p>Facility Administration failed to administer a safe, systematic approach with the use of side rails and failed to conduct regular inspection of all bed frames, mattresses and bed rails as a part of a regular maintenance program.</p> <p>Director of clinical operations in serviced the administrator and maintenance director and Environmental service director on the current federal regulations related to side rail safety and bed entrapment zones on 11/17/17.</p> <p>All staff were in-serviced on 11/17/17-11/18/17 on the bed rail regulation changes. Beginning 11/19/17 all new staff will be in serviced during the orientation process on the bed rail regulation changes.</p> <p>The maintenance director will conduct/zone safety assessments daily for two weeks, weekly for two weeks and then monthly for 2 months and then quarterly to ensure residents safety. Maintenance director completed a 100% audit on 11/18/17 of all residents for the proper bed dimension due to size and weight. Maintenance director also completed an audit of all residents for the risk of entrapment from use of side rails.</p> <p>The facility self-assessment tool 11/18/17 and will be reviewed at least annually by the Administrator, DON, ADON, Medical Director, Activity Director, Dietary Director, Environmental service director</p>		

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F 490	<p>Continued From page 69</p> <p>and new systems put into place had to stay in place. He explained he and the Director of Nursing completed a facility assessment and had discussed the need to purchase new beds but they were a large capital expense for the facility.</p> <p>The Administrator, ADON, Regional Consultant of Clinical Services and Corporate Consultant of Clinical Services were informed of Immediate Jeopardy on 11/18/17 at 3:00 PM.</p> <p>The facility provided an acceptable credible allegation for immediate jeopardy removal on 11/18/17 at 8:45 PM.</p> <p>Credible allegation for Hendersonville Health and Rehabilitation F490- Hendersonville Health and Rehab will assure the facility administers in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;</p> <p>On 11/15/17 at approximately 6:30 AM resident # 1 (Room 108 B) was found by an employee #1. Employee #1, the NA/MA, was working as his medication aide on the 100 hall. She had been working the 7 PM to 7 AM shift. She was on the 100 hall from 11 PM to 7 AM. Employee #1 was in room 108 B @ 5:30 AM and resident #1 was in the bed with his head elevated at approximately 45 degrees. Employee #1 gave him his morning medications and noted nothing abnormal about the resident. Employee #1 returned to room 108 B at approximately 6:30 AM to check his blood</p>	F 490	<p>Maintenance director, social services and MDS Director to incorporate the tags received from this immediate jeopardy and will be brought to QA monthly for the next three months and at least annually to assure compliance.</p> <p>DON and or Administrator revised the facility assessment tool on November 18, 2017 to incorporate the cited deficiencies outlined in the immediate jeopardy.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 70</p> <p>pressure. At that time, Employee #1 noted the top of resident #1's head up to the bridge of his nose was stuck through the side rail on the left side of his bed and his legs were still in the bed. The side rails on both sides of his bed were up. He was on an air mattress. He was talking and answering questions that Employee #1 was asking him. Employee # 1 did not attempt to assist resident #1 at that point. Employee #1 immediately stepped outside the door and asked Employee # 2 (CNA) to get a nurse. Nurse #1, LPN, and Nurse #2 LPN arrived to room 108 B within a minute and arrived within seconds of each other. Both assessed the situation and realized the resident had his head up to the bridge of his nose stuck in the side rail. Nurse #1 left the room to get a lubricant. Nurse #1 returned with the lubricant and both nurses began to move his legs off of the bed to line his body up. They worked to free resident #1 from the side rail for approximately 5 minutes. He began to say he was hurting. The nurses stopped and Nurse #2 LPN called 911.</p> <p>The procedure for implementing the acceptable plan of correction for the specific deficiency cited;</p> <p>Director of clinical operations in serviced the administrator and maintenance director and Environmental service director on the current federal regulation changes.</p> <p>All department heads, licensed/certified staff were in-serviced on the bed rail regulation changes. This will be included in the new hire orientation.</p> <p>On 11/18/17 the Director of Clinical Operations in-serviced the administrator, maintenance director and Environmental service director and</p>	F 490			

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F 490	<p>Continued From page 71 multiple other staff.</p> <p>The facility self-assessment tool will be reviewed by the Administrator, DON, ADON, Medical Director, Activity Director, Dietary Director, Environmental service director Maintenance director, social services and MDS Director and revised to incorporate the tags received from this immediate jeopardy and will be brought to QA monthly for the next three months and at least annually to assure compliance.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;</p> <p>DON and or Administrator will review and revise the facility assessment tool by November 18, 2017 to incorporate the cited deficiencies outlined in the immediate jeopardy. Administrator will review this process.</p> <p>o The title of the person responsible for implementing the acceptable plan of correction.</p> <p>Director of Nursing and Administrator</p> <p>We certify that as of November 18, 2017 the immediate jeopardy will be removed.</p> <p>Immediate Jeopardy was removed on 11/18/17 when interviews with nurses who validated they had received in-service training on bed side rail regulation changes. They also confirmed they had received in-service training on the new side rail assessment forms. Administrative staff which included the EVS Director and Maintenance Director were interviewed and stated they had</p>	F 490			

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F 490	Continued From page 72 been in-serviced on bed side rail regulation changes. The Maintenance Director confirmed he would conduct inspections of beds, mattresses and side rails on a regular basis. 5. Cross refer to F 461: Based on observations, record review and staff interviews the facility failed to conduct regular inspection of all bed frames, mattresses and bed rails as a part of a regular maintenance program and a resident (Resident #1) got his head stuck in the side rail of his bed and his head had to be released from inside the rail by fire rescue personnel in 1 of 81 beds with side rails with openings that had the potential for entrapment out of a total of 130 beds in the facility. The facility was cited at tag F461 at a scope and severity level of E.	F 490			
F 520 SS=J	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520		1/2/18	

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F 520	<p>Continued From page 73</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey of 07/20/17. This was for one recited deficiency which was originally cited in July 2017 and was subsequently recited on a complaint survey on 11/19/17. The repeat deficiency was in the area to develop a comprehensive care plan. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>Immediate Jeopardy began on 11/06/17 when the</p>	F 520	<p>During Hendersonville Health and Rehabs last recertification survey the facility was given a tag for F279 and is now regarded as a repeat citation due to not care planning for side rails. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effect Quality Assurance Program related to not developing a comprehensive care plan (to include side rails). On 11/18/17 Administrator, DON and ADON re-evaluated the buildings process to ensure that the issues addressed during this immediate jeopardy process</p>		

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F 520	<p>Continued From page 74</p> <p>facility failed to develop a comprehensive care plan for the use of side rails for Resident #1. Immediate Jeopardy was removed on 11/18/17 when the facility provided and implemented a Credible Allegation of Compliance. The facility remains out of compliance at a scope and severity level of D (Isolated with no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>F279: Develop a Comprehensive Care Plan: Based on observation, record review and staff interviews the facility failed to develop a comprehensive care plan which included side rails as a potential restraint when a resident got his head stuck in the side rail of his bed and his head had to be released from inside the side rail by fire rescue personnel for 1 of 1 resident reviewed for restraints (Resident #1).</p> <p>During the recertification survey of July 20, 2017 the facility was cited at F 279 for failure to develop a comprehensive care plan to include side rails as a restraint for 1 or 1 sampled resident.</p> <p>During an interview on 11/19/17 at 2:40 PM, the Administrator explained the facility conducted monthly Quality Assurance meetings and the Administrator, Director of Nursing (DON), Medical Director, Pharmacist and all of the department managers attended the meetings.</p> <p>The Administrator stated he had no excuse as to</p>	F 520	<p>will be audited and followed through monthly with our QA process. The facility side rail assessment was reviewed by the Quality Assurance Team and was updated to reflect resident's cognition, physical function and bed size appropriateness and entrapment zone areas for assessment. CNA care guides were reviewed by the quality assurance team and were updated to include instruction related to use of side rails for each resident in the facility. The 48 hour care plans were reviewed by the quality assurance team and were updated to include instruction related to use of side rails for each resident in the facility. All resident 21 day care plans were reviewed by the quality assurance team and were updated to include instruction related to use of side rails for each resident in the facility.</p> <p>The Director of Nursing and Assistant Director of Nursing educated the licensed nurses, to include the MDS nurses on completion of updated Side Rail Assessment, the updated CNA care guide, the updated 48 hour care plan, the updated 21 day care plan.</p> <p>The new side rail assessment was completed on 100% of residents in the facility. 100% of CNA care guides were updated, 100% of 48 hour care plans were updated, 100% of resident 21 day care plans were updated by 11/18/17 DON and ADON or designee will audit the resident side rail assessment, 48 hour and working care plan on each admission and or readmission to ensure compliance MDS Rn's will review the side rail</p>		

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F 520	<p>Continued From page 75</p> <p>why the F279 was a repeat citation but he would work his hardest to prevent it from happening again.</p> <p>The Administrator, Assistant Director of Nursing (ADON) and Regional Consultant of Clinical Services and Corporate Consultant of Clinical Services were informed of Immediate Jeopardy on 11/18/17 at 3:00 PM.</p> <p>The facility provided an acceptable credible allegation for immediate jeopardy removal on 11/18/17 at 7:33 PM.</p> <p>Credible Allegation for Hendersonville Health and Rehabilitation for F279 - Hendersonville Health and Rehab will assure the facility develops and implements a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care. On 11/15/17 Hendersonville Health and Rehab re-evaluated their processes to ensure the residents proper development and implementation of the baseline care plan.</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;</p> <p>Resident #1 did not have a care plan that addressed the use of side rails.</p> <p>" The for implementing the acceptable plan of correction for the specific deficiency cited;</p> <p>On November 18, 2017 DON, ADON and RCM audited all the residents care plans in regards to the proper use of side rails. 100 % of the CNA Care Guides, Interim Care Plans and Care Plans were updated to reflect the usage of side rails.</p>	F 520	<p>assessment and implement the 21 day care plan, quarterly assessment and with any significant change in condition. Any future significant changes will be documented on the care plan and the MDS RN will review daily for 2 weeks (100%), weekly for 2 weeks (50%) and then monthly for 2 months (10%).</p> <p>The QA Executive Committee members will audit findings X 3 months.</p>		

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F 520	<p>Continued From page 76</p> <p>Side rail assessments will be completed upon admission, re-admission, quarterly, and with any significant change in the resident's condition.</p> <p>In addition MDS completed a 100% of all MDS assessments for accuracy in regards to proper side rail usage with no discrepancies.</p> <p>" The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;</p> <p>Upon admission the DON, ADON will review the 48 hour care plan then will review the working care plan and the 21 day care plan in order to ensure continued compliance. Any future significant changes will be documented on the care plan and the DON and ADON will review for compliance.</p> <p>The title of the responsible for implementing the acceptable plan of correction.</p> <p>" Director of Nursing and Administrator</p> <p>We certify that as of November 18, 2017 the immediate jeopardy will be removed.</p> <p>Immediately Jeopardy was removed on 11/18/17 when interviews with the nurses and NA's revealed they were inserviced on the resident care plans that had been updated regarding the use of side rails.</p>	F 520			