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	345211	A. BUILDING ______ B. WING ______	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	**2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563**

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/23/24 through 9/26/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #IZN911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/23/24 through 9/26/24. Event ID# IZN911. The following intakes were investigated NC00215934 and NC00217444. Two of the two complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of falls (Resident #17), oxygen (Resident #56), and discharge status (Resident #93). This was for 3 of 3 residents reviewed for Minimum Data Set assessments. The findings included: a. Resident #17 was admitted to the facility on 2/25/19 with diagnoses that included diabetes, chronic kidney disease, and hypertension.	F 641	F641 Accuracy of Assessments On 9/24/24, the Staff Development Nurse completed a modification of the MDS assessment completed 6/20/24 for resident #17 to reflect accurate coding of falls. On 9/25/24, the Minimum Data Set consultant (MDS) completed a modification of the MDS assessment completed 8/29/24 for resident #56 to reflect accurate coding for use of oxygen.	10/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/10/2024

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.

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F 641	Continued From page 1 A review of a nurse progress note written by Nurse #1 dated 4/2/24 revealed Resident #17 had a fall. A review of Resident #17's Quarterly Minimum Data Set assessment dated 6/20/24 did not indicate she had a fall. In an interview with MDS Nurse #1 on 9/24/24 at 11:17 AM she stated changes in resident conditions were discussed with the interdisciplinary team (IDT) (a group of healthcare professionals who work together to treat a resident) each morning. MDS Nurse #1 stated the MDS assessment completed on 6/20/24 should have indicated Resident #17 had a fall. She stated she was not sure how the error occurred. In an interview with MDS Nurse #2 on 9/24/24 at 11:18 AM she stated the MDS assessment completed on 6/20/24 should have indicated Resident #17 had a fall. She stated she failed to code the fall related to human error. In an interview with the DON on 9/24/24 at 11:24 AM she stated all falls were reviewed with IDT team each morning and when the MDS Nurse's received the information, they should have coded it in the MDS. In an interview with the Administrator on 9/25/24 at 4:08 PM she stated the MDS assessment should accurately reflect resident falls. b. Resident #56 was admitted to the facility on 8/23/24 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD). A review of Resident #56's medical record	F 641	On 9/24/24, the Staff Development Nurse (MDS) completed a modification of the MDS assessment completed 9/12/24 for resident #93 to reflect accurate coding discharge location. On 10/7/24, the MDS consultant initiated an audit of the most recent MDS assessment sections A, section J and section O to ensure all residents are coded accurately for falls, use of oxygen and location of discharge. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversite from DON. The audit will be completed by 10/21/24. On 9/24/24, the Director of Nursing initiated an in-service with all MDS nurses regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on ensuring assessments are coded accurately on the MDS assessment to include but not limited to resident falls, use of oxygen and location of discharge. The in-service will be completed by 10/21/24. After 10/21/24 any MDS nurse who has not worked or received the in-service will complete it prior to the next scheduled work shift. All newly hired MDS nurses will be in-service regarding MDS Assessments and Coding during orientation. The Director of Nursing will audit of 10% of newly completed MDS assessments utilizing the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS	

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Continued From page 2

revealed a Physician's order dated 8/23/24 for oxygen to be delivered at 2 liters per minute via nasal cannula continuously.

A review of the admission Minimum Data Set (MDS) dated 8/29/24 did not indicate Resident #56 used oxygen.

A review of Resident #56's Medication Administration Record revealed she had been receiving oxygen at 2 liters per minute continuously since admission.

An interview with MDS Nurse #1 on 9/24/24 at 2:52 PM revealed changes in resident conditions were discussed with the interdisciplinary team (IDT) (a group of healthcare professionals who work together to treat a resident) each morning. MDS Nurse #1 stated the MDS assessment completed on 8/29/24 should have indicated Resident #56 used oxygen. She indicated coding for oxygen was missed due to human error.

In an interview with the Administrator on 9/24/24 at 2:57 PM she stated the MDS assessment should have accurately reflected Resident #56's oxygen use.

In an interview with the Director of Nursing (DON) on 9/25/24 at 12:55 PM she stated Resident #56's MDS should have been coded for oxygen use.

c. Resident #93 was admitted to the facility on 8/23/24. Her active diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, and hypertension.

Review of Resident #93's progress note dated

F 641

assessment to include resident falls, use of oxygen and location of discharge. All identified areas of concern will be addressed immediately by the DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed.

The DON will forward the results of MDS Accuracy Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the MDS Accuracy Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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F 641	Continued From page 3 9/12/24 revealed she was discharged home. Review of Resident #93's discharge Minimum Data Set (MDS) assessment dated 9/12/24 revealed she was coded as discharged to a short-term general hospital. During an interview on 9/24/24 at 2:38 PM MDS Nurse #2 stated Resident #93 was discharged home and the discharge MDS dated 9/12/24 was marked in error. During an interview on 9/24/24 at 2:57 PM the Administrator stated MDS assessments should accurately reflect residents' discharge status.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(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 - (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 (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).	F 656		10/21/24

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F 656	Continued From page 4 (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 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan that included the diagnosis of diabetes mellitus and the use of hypoglycemic medication for 1 of 5 residents (Resident #61) reviewed for unnecessary medication. Findings included: Resident #61 was admitted to the facility on 10/18/21 with a diagnosis of diabetes mellitus. A review of his quarterly Minimum Data Set	F 656	F 656 Develop/Implement Comprehensive Care Plan On 9/25/24, the Minimum Data Set Nurse (MDS) under the oversight of the Director of Nursing (DON) updated the care plan for resident #61 to accurately reflect the diagnosis of Diabetes and the use of hypoglycemic medication. On 10/7/24, the Administrator and facility consultant initiated an audit of care plans for all diabetic residents to ensure the	

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F 656	Continued From page 5 (MDS) assessment dated 6/25/24 revealed he was taking hypoglycemic medication. A physician's order dated 1/25/24 indicated to give Resident #61 one 500 milligram tablet of metformin extended release (a hypoglycemic medication) once daily in the morning related diabetes mellitus. A review of his comprehensive care plan dated last reviewed on 7/26/24 did not reveal any focus area, goals, or interventions related to Resident #61's diagnosis of diabetes mellitus or his use of hypoglycemic medication. On 9/25/24 at 8:11 AM an interview with MDS Nurse #1 indicated she was the MDS Coordinator. She stated Resident #61's comprehensive care plan was last reviewed by the interdisciplinary team from 7/2/24 through 7/9/24. She stated she did not see Resident #61's diabetes mellitus or his use of hypoglycemic medication addressed in his current comprehensive care plan. She reported it would have been her responsibility to include this, she should have caught it on his last care plan review, and she had missed it. MDS Nurse #1 stated this was a human error. On 9/25/24 at 4:05 PM an interview with the Director of Nursing indicated Resident #61's diabetes mellitus and his use of hypoglycemic medication were things that should be included in his comprehensive care plan. On 9/26/24 at 9:50 AM an interview with the Administrator indicated Resident #61's diabetes mellitus and use of hypoglycemic medication should have been reflected in his comprehensive	F 656	care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include but not limited to the diagnoses of diabetes and the use of hypoglycemic medication. The nurse supervisors will address all concerns identified during the audit to include updating care plan when indicated and/or education of staff. The audit will be completed by 10/21/24. On 10/7/24, the Staff Development Coordinator initiated an in-service with all nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include but not limited to the diagnosis of diabetes and use of hypoglycemic medication. In-service will be completed by 10/21/24. After 10/21/24, any nurse who has not completed the in-service will be in-service prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Care Plans. The Unit Managers will review 10% care plans for residents with the diagnosis of diabetes and residents receiving hypoglycemic medication to include resident #61 weekly x 4 weeks, then monthly x 1 month, utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan is person centered for all	

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F 656	Continued From page 6 care plan.	F 656	aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include but not limited to residents who use supplemental oxygen. The Unit Managers will address all concerns identified during the audit to include updating care plan when indicated and re-education of staff. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to provide incontinence care to a severely cognitively impaired dependent resident. This was for 1 of 3 residents (Resident #45) reviewed for activities of daily living. This placed Resident #45 at risk for skin integrity impairment.	F 677	F677 ADL Care Provided for Dependent Residents On 9/25/24 at 2:18 PM, Resident #45 was provided incontinence care by nursing assistant (NA) #1 under the direct oversight of the Director of Nursing	10/21/24

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Continued From page 7

Findings included:

Resident #45 was admitted to the facility on 11/29/21 with a diagnosis of cerebral infarction (disrupted blood supply to the brain).

A review of Resident #45's care plan last updated 5/30/24 revealed a focus area for activities of daily living. The goal was for Resident #45's activities of daily living to be completed with staff support. An intervention was dependence for toileting hygiene and incontinence of bladder.

A review of Resident #45's quarterly Minimum Data Set (MDS) assessment dated 8/15/24 revealed he was severely cognitively impaired. He had functional impairment in range of motion on both sides of his upper and power extremities. He was dependent for toileting hygiene. He was always incontinent of bowel and bladder. He had no pressure ulcers, skin conditions, or moisture associated skin damage.

A review of Resident #45's full body skin assessment dated 9/20/24 completed by Nurse #5 did not indicate any skin redness, irritation, or breakdown.

On 9/25/24 at 2:02 PM Resident #45 was observed lying in his bed. A portion of the bottom of his blanket was pulled back and the edge of his incontinence pad visible. This pad was observed to have a yellowish wet ring. There was the slight odor of urine. An interview with Resident #45 at that time indicated he was doing fine. He stated he had already had his bath that morning and he did not need anything.

F 677

(DON). No redness, irritation, or skin breakdown was observed to Resident #45's perineal area or buttocks.

On 9/25/24, NA #1 was verbally educated by the Director of Nursing regarding ADL care with emphasis on ensuring residents received care timely to include incontinent care and/or notification of the nurse, nurse supervisor or DON if care cannot be provided timely so care can be arranged by alternative staff. NA#1 verbalized understanding.

On 9/25/24, Unit Managers completed an audit of incontinent care for all residents not able to report to ensure all residents were provided care timely and per resident preference. There were no additional concerns identified.

On 9/25/24, the Administrator completed questionnaires with all alert and oriented residents regarding incontinent care. The questionnaires were to identify any concerns related to receiving assistance with ADL care to include incontinent or toileting assistance. There were no additional concerns identified.

On 9/25/24, the Staff Development nurse initiated an in-service with all nursing assistants regarding Incontinent Care with emphasis on monitoring residents frequently for needs to include but not limited to incontinent care, providing care timely and/or immediately notifying the nurse, nurse supervisor or DON if care cannot be provided timely so care can be

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F 677	Continued From page 8 On 9/25/24 at 2:12 PM an interview with Nurse Aide (NA) #1 indicated she was assigned to care for Resident #45 on the 7AM-3PM shift that day. She stated she was familiar with Resident #45. She reported Resident #45 did not use his call bell for assistance, and he was always incontinent of bowel and bladder. NA #1 went on to say Resident #45 had not had his bath yet, and she had not been in his room to check him for incontinence or provide him with any incontinence care since she began her shift at 7:00 AM that morning. She stated she had a really demanding resident who had taken up a lot of her time that day, and she had not had a chance to get to Resident #45. She reported she had not asked anyone to help her, or let the nurse know she had not been able to get to Resident #45. NA #1 reported she felt if she had asked the nurse for help, the nurse would have helped her. She went on to say Resident #45 should have been checked for incontinence at least every 2 hours and incontinence care provided to him if he needed this. On 9/25/24 at 2:18 PM an observation of Resident #45's incontinence care was conducted with the Director of Nursing (DON) and NA #1. The DON stated Resident #45's incontinence pad was wet, and his incontinence brief was saturated with urine and the odor of urine was present. No redness, irritation, or skin breakdown was observed to Resident #45's perineal area or buttocks. During the observation, NA #1 confirmed to the DON that she had not checked Resident #45 for incontinence since she started her shift at 7 AM that morning or provided him with incontinence care yet that day. The DON stated she was very upset and disappointed and could not understand why NA #1 had not provided	F 677	provided by alternative staff. The in-service will be completed by 10/21/24. After 10/21/24, any nursing assistant who has not worked or completed the in-service will complete it upon the next scheduled work shift. All newly hired nursing assistants will be educated during orientation. The Unit Managers will complete 10 resident care audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure that staff monitored residents frequently and provided incontinent care timely or immediately notified the nurse, nurse supervisor or DON when care could not be provided timely so care could be arranged by alternative staff. The Unit Managers will address all areas of concern identified during the audit to include providing care when indicated and/or re-training of staff. The DON will review the Resident Care Audits weekly for 4 weeks, then monthly for one month to ensure all areas of concern are addressed. The DON will forward the results of the Resident Care Audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 677	Continued From page 9 Resident #45 this care. The DON reported Resident #45 was always incontinent and didn't use his call bell. She went on to say NA #1 should have checked Resident #45 for incontinence at least every 2 hours and provided him with incontinence care if he needed it. She stated going 7 hours without this care put Resident #45 at risk for skin breakdown. The DON reported if NA #1 had not been able to provide Resident #45 with care for whatever reason, NA #1 should have asked a nurse, a unit manager, or herself and someone would have gladly assisted. On 9/25/24 at 2:23 PM an interview with Nurse #4 indicated she was assigned to care for Resident #45 on the 7AM-3PM shift that day. She stated she was not aware that Resident #45 had not received any incontinence care yet that day, and NA #1 had not asked her for any help providing this or she would have gladly assisted. Nurse #4 did not indicate she checked Resident #45 for incontinence or provided any incontinence care to Resident #45 that day. On 9/25/24 at 3:26 PM an interview with Unit Manager #2 indicated she was the Unit Manager for the hall where Resident #45 resided. She stated she had been on Resident #45's hall at both the breakfast and lunch meals that day, and NA #1 had not asked her for any assistance with providing incontinence care to Resident #45. On 9/26/24 at 9:58 AM, a follow-up interview with Unit Manager #2 indicated she had been in Resident #45's room on 9/25/24 to deliver his breakfast and lunch meals. She stated she had not checked him for incontinence or provided him with any incontinence care. She went on to say she had not noticed any urine odor, and Resident #45 had not requested any care.	F 677		

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F 677	Continued From page 10 On 9/25/24 at 3:41 PM an interview with Nurse #5 indicated she conducted Resident #45's full body skin assessment dated 9/20/24. She stated Resident #45 had no skin redness, irritation or breakdown observed during this assessment. On 9/26/24 at 7:55 AM a telephone interview with NA #2 indicated she had been assigned to care for Resident #45 on 9/24/24 at 11:00 PM until 9/25/24 at 7:00 AM. She stated she had last provided Resident #45 with incontinence care at 5:00 AM on 9/25/24 before she finished her shift at 7:00 AM that morning. On 9/26/24 at 9:50 AM an interview with the Administrator indicated she would have expected Resident #45 to be provided with incontinence care in a timely manner. She stated although Nurse #4 had been in Resident #45's room to administer his morning and lunch time medications, and Unit Manager #2 had been in his room during his breakfast and lunch meals, and he had not indicated he needed anything; he should have received incontinence care every 2 hours as needed	F 677		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of	F 700		10/21/24

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RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

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F 700	Continued From page 11 entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing siderails for 2 of 2 residents (Resident #27, Resident #56) reviewed for accidents. Findings included: 1. Resident #27 was admitted to the facility on 9/23/21 with a diagnosis of vascular dementia and chronic obstructive pulmonary disease (COPD). A review of Resident #27's record revealed an assessment titled "physical device use evaluation" dated 7/23/24 and completed by Unit Manager (UM) #1 indicated no alternatives to one quarter siderails were attempted before use. A Quarterly Minimum Data Set (MDS) dated 8/14/24 revealed Resident #27 was severely cognitively impaired. The MDS indicated Resident #27 required partial to moderate assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #27 had an	F 700	F700 Bedrails Resident #56 no longer resides in the facility. On 9/27/24, resident #27 was re-evaluated for use of bed rails by the therapy. Previous interventions attempted included physical and occupational therapy in April 2024, frequent assistance for transfers, medication review October 2024. The resident was previously on toileting program in February 2024, but due decline is unable to participate in a toileting program currently. The resident declined use of bolsters/wedges. The use of bed rails was determined to be the most appropriate for the resident to maximize potential for bed mobility. On 10/7/24, the Administrator, Director of Nursing, Unit Managers, and therapy initiated an audit of all residents utilizing bed rails. This audit is to ensure	

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F 700	Continued From page 12 impairment of both upper and lower extremities. The MDS indicated Resident #27's siderails were not used as a restraint. A care plan with the latest review date of 8/14/24 revealed a problem of use of siderails for increasing or maintaining current bed mobility. The goal was Resident #27 would continue to use siderails safely for facilitating bed mobility and transfers through next review. Interventions included: use of siderails to assist resident to enter and exit the bed independently and use of siderails to assist resident to turn and reposition when in bed. An observation on 9/24/24 at 2:35 pm revealed Resident #27 lying in bed with bilateral one-quarter length siderails in the up position on the bed. An observation 9/25/2024 at 2:04 PM revealed Resident #27 sitting in her wheelchair next to her bed. The siderails were observed to be in the raised position. An interview with Nurse #2 on 9/25/24 at 9:25 AM revealed the Nurses completed the physical device use evaluation on admission and quarterly. Nurse #2 stated this form was used for siderail screening. She further stated she always answered no to the question "Of these alternatives, which have been attempted (i.e. rehab screening, restorative nursing program, toileting schedule, activity programming, assistive devices, medication review, pain management, room change, etc.)?" Nurse #2 indicated siderails were on the beds on admission. Newly admitted residents began using the siderails immediately. She further indicated Nursing did not try	F 700	appropriate alternatives to maximize residents potential for bed mobility were attempted prior to installing a side or bed rail and that if a side/bed rail is used, the resident was assessed for appropriateness to include risks for entrapment with education of the resident and/or resident representative regarding the risks/benefits for use of a side/bed rail. The therapy staff, Unit Unit Managers, Director of Nursing, Administrator and maintenance staff will address all concerns identified during the audit to include initiating appropriate alternatives when indicated, assessment of the resident for appropriate use of bed rails, education of the resident/resident representative on the risks/benefits for use of a side/bed rail and/or education of staff. The audit will be completed on 10/21/24. On 10/7/24, the Staff Development nurse initiated an in-service regarding Bed Rails with all nurses and maintenance staff with emphasis on (1) The facility must attempt to use appropriate alternatives prior to installing a side or bed rail (trapeze bar, low beds, frequent monitoring, activities) (2) Assessing the resident for the risk of entrapment bed rails prior to installation under the Physical Device Assessment to include alternative previously attempted (3) Review the risks/benefits of bed rails with the resident or resident representative and obtain informed consent, (4) Ensure the rail is installed per the manufactures recommendations/ specifications, compatible with the	

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F 700	Continued From page 13 alternatives to siderails before they were used. In an interview with UM #1 she stated she recalled completing the physical device use evaluation for Resident #27. She further stated she was not aware of a time the facility tried alternatives to siderails. UM #1 revealed siderails were always on the beds unless they were removed by request of the resident, the residents responsible party or physical therapy. She was not aware alternatives to side rails needed to be attempted before using them. In an interview with the Director of Nursing (DON) on 9/25/24 at 12:55 PM she stated Nursing completed the physical device use evaluation on admission and quarterly. She further stated they did not try interventions before using siderails as she was not aware this was a requirement. The DON indicated that siderails were only taken off the beds if found to be contraindicated for a resident or if a resident or resident representative declined them. In an interview with the Administrator on 9/25/24 at 8:45 AM she stated siderails were not removed from the beds unless the resident or their representative declined them, or if they were found to be a danger to the resident. She further stated alternative interventions to the siderails were not tried first. 2. Resident #56 was admitted to the facility on 8/23/24 end stage renal disease with dependence on renal dialysis, Chronic Obstructive Pulmonary Disease (COPD) and fracture of the right femur (upper leg bone). A review of Resident #56's record revealed an	F 700	mattress and bed frame and that the dimensions are appropriate for the residents size and weight (6) Inspect regularly to ensure rail is installed correctly with no loosening to prevent the possibility of entrapment and (7) the resident is care planned for the use of bed rails. The in-service will be completed by 10/21/24. After 10/21/24, any nurse or maintenance staff who have not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses or maintenance staff will be educated during orientation. The Unit Managers and/or Director of Nursing (DON) will audit 10% of all residents utilizing bed rails weekly x 4 weeks, then monthly x 1 month utilizing the Bed Rail Audit Tool to ensure the facility attempted use of appropriate alternatives prior to installing a bed rail, the resident was assessed using the physical device assessment if bed rails used to include previously attempted alternatives, risks/benefits for use, education of the resident/resident representative on the risks/benefits of using a bed rail, the care plan is updated for the use of bed rails and the bed rail was installed according to manufacturer□s recommendations/specifications. The Unit Managers and/or DON will address all concerns identified during the audit to include but not limited to attempting appropriate alternatives, assessment of the resident, education of the resident/resident representative on the	

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F 700	Continued From page 14 assessment titled "physical device use evaluation" dated 8/23/24 and completed by Nurse #3 indicated no alternatives to one quarter siderails were attempted before use and a medical symptom for use of siderails was not found. A 5-day Minimum Data Set (MDS) dated 8/29/24 revealed Resident #56 was moderately cognitively impaired and had no impairment of upper extremities and did have impairment in lower extremities. The Resident required substantial assistance with rolling in bed, sitting to lying and sit to stand. The MDS indicated Resident #56's siderails were not used as a restraint. A care plan with the latest review date of 8/23/24 revealed a problem of use of siderails for increasing or maintaining current bed mobility. The goal was Resident #56 would continue to use siderails safely for facilitating bed mobility and transfers through next review. Interventions included: Use of siderails to assist resident to increase ability to enter and exit the bed at highest practical mobility level and use of siderails to assist resident to turn and reposition when in bed. An observation on 9/23/24 at 9:38 AM revealed Resident #56 in bed with the one-quarter length siderails in the raised position. An observation 9/25/2024 at 2:28 PM revealed Resident #56 in bed with bilateral one-quarter length siderails in the up position on the bed. Nurse #3 could not be reached for an interview.	F 700	risks/benefits of using a bed rail, installing bed rail according to manufacturer□s recommendations and/or re-training of staff. The Administrator will review the Bed Rail Audit Tools weekly x 4 weeks, then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the results of the Bed Rail Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 700	Continued From page 15 An interview with Nurse #2 on 9/25/24 at 9:25 AM revealed the Nurses completed the physical device use evaluation on admission and quarterly. Nurse #2 stated this form was used for siderail screening. She further stated she always answered no to the question "Of these alternatives, which have been attempted (i.e. rehab screening, restorative nursing program, toileting schedule, activity programming, assistive devices, medication review, pain management, room change, etc.)?" Nurse #2 indicated siderails were on the beds on admission. Newly admitted residents began using the siderails immediately. She further indicated Nursing did not try alternatives to siderails before they were used. In an interview with the Director of Nursing (DON) on 9/25/24 at 12:55 PM she stated Nursing completed the physical device use evaluation on admission and quarterly. She further stated they did not try interventions before using siderails. The DON indicated that siderails were only taken off the beds if found to be contraindicated for a resident or if a resident or resident representative declines them. She was not aware alternative interventions to siderails needed to be tried before implementation of siderails. In an interview with the Administrator on 9/25/24 at 8:45 AM she stated siderails were not removed from the beds unless the resident or their representative declines them, or if they were found to be a danger to the resident. She further stated alternative interventions to the siderails were not tried first. The Administrator was not aware alternatives to siderails needed to be attempted before siderail use.	F 700		
F 880 SS=D	Infection Prevention & Control	F 880		10/21/24

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F 880		F 880		

Continued From page 16
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a

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F 880	Continued From page 17 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to handle soiled linen in a manner to prevent the spread of infection. This was for 1 of 2 staff members observed for infection control practices during activities of daily living care (Nurse Aide #1). Findings included: A review of the facility's policy titled: "Linen	F 880	F880 Infection Control On 9/25/24, the Director of Nursing verbally educated nursing assistant #1 (NA) regarding Handling of Linen with emphasis on never placing soiled linen on the floor and bagging all soiled linen before exiting resident room and placing in soiled linen container. The NA verbalized understanding.	

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F 880	Continued From page 18 Handling" dated 4/2023 revealed in part: "All soiled linen should be considered as contaminated. The risk of actual disease transmission from soiled linen with pathogenic microorganisms is insignificant if handled, transported, and laundered in a way that avoids the transfer of microorganisms. Soiled linen should be bagged or placed in containers at the location where it is used. Wet and/or soiled linens should be placed and transported in leak proof bags." On 9/25/24 at 10:29 AM an continuous observation of bathing activity was conducted for Resident #1 with Nurse Aide (NA #1). At the conclusion of the activity at 11:25 AM NA #1 removed her soiled gloves, performed hand hygiene and applied clean gloves. NA #1 was observed to pick the soiled linen up from the floor while wearing her gloves, open Resident #1's room door, transport the linen out into the hallway, and place it into the soiled laundry hamper which was positioned outside the door to Resident #1's room. NA #1 then removed her gloves and performed hand hygiene. An interview with NA #1 at that time, after leaving Resident #1's presence, indicated the linen on the floor of Resident #1's room was the soiled linen from Resident #1's bath. NA #1 stated sometimes she placed resident's soiled linen into a bag after their bath if she needed to transport the soiled linen down the hallway, but if the linen hamper was outside the room like it was today, she would pick the linen up from the floor and place into the laundry hamper without putting it into a bag first. On 9/25/24 at 4:05 PM an interview with the Director of Nursing (DON) indicated she was also serving as the facility's Infection Preventionist.	F 880	On 10/7/24, the Unit Managers completed 10 random observations of nursing assistants handling of soiled linen. This observation was to ensure staff did not place soiled linen on the floor and utilized appropriate technique when transporting linen from resident care areas to include bagging linen per facility protocol. There were no additional concerns identified. On 9/25/24, the Staff Development Nurse initiated an in-service with all nursing assistants regarding Handling of Linen with emphasis on (1) all soiled linen should be considered as contaminated (2) never place soiled linen on the floor and (3) Soiled linen should be bagged or placed in containers at the location where it is used. Wet and/or soiled linens should be placed and transported in leak proof bags. The in-service will be completed by 10/21/24. After 10/21/24, any nursing assistant who has not worked or completed the in-service will complete it upon the next scheduled work shift. All newly hired nursing assistants will be educated during orientation. The Unit Managers will complete 10 observations to include all shifts weekly x 4 weeks then monthly x 1 month utilizing the Linen Audit Tool. This audit is to ensure staff did not place soiled linen on the floor and utilized appropriate technique when transporting linen from resident care areas to include bagging linen per facility protocol. The Unit Managers will address all concerns	

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F 880	Continued From page 19 She stated NA #1 should not be placing soiled linen directly on the floor in resident's rooms. She went on to say this was an infection control issue because it could result in the cross contamination of microorganisms. The DON reported NA #1 should be placing soiled linen directly into a bag for transport. On 9/26/24 at 9:50 AM an interview with the Administrator indicated soiled linen should be bagged for transportation unless it could be placed directly into the soiled linen hamper and should not be placed on the floor in resident's rooms.	F 880	identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Linen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Linen Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	