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	345175	A. BUILDING _____ B. WING _____	C 10/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR NURSING AND REHAB	902 BERKSHIRE ROAD SMITHFIELD, NC 27577

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation of 10/06/2017 Event CV5B11. A recertification survey was conducted from 10/02/17 through 10/06/17. Immediate Jeopardy was identified at: CFR 483.10 at tag F221 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) The tags F221 and F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 06/27/17 for resident #167 and on 10/02/17 for resident #19 and was removed on 10/06/17. An extended survey was conducted.	F 000		
F 221 SS=J	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. 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). 42 CFR §483.12, 483.12(a)(2)	F 221		10/28/17

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

Electronically Signed | 10/24/2017

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F 221	Continued From page 1 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. (a) The facility must- (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 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility utilized a device without considering it to be a restraint and without a medical symptom for 2 of 4 residents (Resident #167 and Resident #19) when Resident #167 was observed by staff with his legs between the side rail bars and required staff assistance to remove his legs from the side rail and for Resident #19 who was observed with both legs between the side rail bars which required staff assistance to remove her legs and sustained a skin tear. Immediate Jeopardy began on 6/27/2017 when Resident #167 was observed by staff with his legs between the side rail bars. Immediate Jeopardy began on 10/2/2017 for Resident #19 both of the resident's legs were between the side rail bars and required staff assistance to remove. The	F 221	The process leading to cited deficiency was: 1. Resident #167 was diagnosed as a having cerebral infarction, dementia and cognitively impaired. He was extensive assist with two person assist required in bed mobility. He was noted to be anxious and restless moving body/legs across bed. Resident found with both legs in between side rail on numerous occasions on 6/27/17. 2. Resident # 19 was diagnosed has having functional quadriplegia, dementia and depressive disorder. The resident was cognitively impaired. The resident was assessed as being total care two person assist in bed mobility. She was found to have both legs between the side-rail on 10/2/17. While repositioning	

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F 221	Continued From page 2 Immediate Jeopardy was removed on 10/6/2017 when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education to ensure monitoring systems are in place that are effective. Findings included: 1-Record review revealed resident #167 was admitted to the facility on 4/21/2017 with diagnoses which included Cerebral Infarction and Anxiety Disorder. Record review revealed the Care Plan initiated 4/25/2017 included a problem of the risk for falls due to impaired mobility and severely impaired cognition. Interventions included the bed in low position, dependent lift for transfers, mat at bedside, and give resident verbal reminders not to transfer without assistance. The last comprehensive (Admission) Minimum Data Set (MDS) dated 4/28/2017 and the most recent quarterly assessment dated 8/2/2017 indicated the Resident #167 was rarely/never understood, had short and long term memory problems, and was severely impaired for daily decision making. The MDS indicated the resident required extensive to total assistance of 1 to 2 persons with all activities of daily living (ADLs) and bed mobility, required total assistance for transfers and had no impairment to upper or lower extremities and had no impairment to upper or lower extremities. The MDS indicated physical restraints which included bed rails, trunk restraints or limb restraints were not used for the resident.	F 221	resident to remove legs from side-rail by C.N.A., a skin tear to the right lower leg was sustained. The plan of correcting the specific deficiency included as follows: On October 5th, 2017 the Assistant Director of Nursing and Staff Development Coordinator re-assessed Resident #167 and #19 using the Side Rail Rationale Screen assessment tool. The side rails were discontinued and removed by Environmental Services for both Resident #167 and Resident #19□s beds. Resident #167 and Resident #19□s care plans were reviewed by the Resident Care Coordinator to ensure safety measures and the level of assistance required for activities of daily living (emphasis on bed mobility and transfer) accurately reflected the resident(s) status. There were no changes made to the resident care plans since safety measures and fall prevention interventions were already in place and remained applicable. There were also no changes in the level of assistance needed as documented in the residents plan of care. The side rails were removed on 10/5/17 and the care plan was updated on the same date. The procedure for implementing the acceptable plan of correction for the specific deficiency cited included as follows: Based on the root cause analysis findings, we determined a more comprehensive side rail-screening process was needed to assist the interdisciplinary team in deciding when side rails would be utilized. This process helped to assure through assessment the	

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F 221	Continued From page 3 The Care Area Assessment (CAA) dated 4/28/2017 indicated the Resident #167 was at a risk for falls and was significantly and severely cognitively impaired. The CAA indicated falls and cognition would trigger to the care plan. Record review of nursing notes revealed a note dated 6/27/2017 at 11:15 PM which reported the Resident #167 was awake the entire shift, was agitated and restless and was observed with his legs between the side rail bars frequently during the shift. The note indicated the resident was repositioned numerous times. The note further indicated the nurse would request an order for padded side rails. A physicians order dated 6/28/2107 for the back side rail to be padded was in the medical record. Record review revealed a Side Rail Rationale Screen assessment dated 8/4/17 for Resident #167. The resident was assessed as non-ambulatory with an alteration in safety awareness due to cognition. The assessment screen indicated the resident demonstrated difficulty moving to a sitting position, difficulty with balance and poor trunk control, and was on medications which required increased safety precautions. The assessment screen indicated the side rail was used for positioning and back support, and was indicated for the resident as an enabler which promoted independence. An observation was conducted of the Resident #167 on 10/05/2017 8:53 AM. The resident was observed in bed sleeping. The head of the bed was raised approximately 35 degrees. A full side rail was on the right side of the bed in a raised position. There was grey colored foam- like thin	F 221	purpose of the side rails so that they did not pose safety risks such as entrapment for the resident(s). The process also help to identify bed rails as physical restraints, particularly in cognitively impaired residents as they were not utilized to treat medical symptoms for these two residents. Individual interventions were implemented based on the reassessment of the two residents. Staff were re-educated on all shifts for these two residents and for all existing and future residents. Education included direct instruction from CMS's RAI manual with emphasis on section (P)Restraints and Alarms and the definitions of restraints as well as Bed Rails and facility policy "Proper Use of Side Rails." The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory is: On October 6th, 2017, the Director of Compliance amended the policy entitled Proper Use of Side Rails to require completion of the Side Rail Rationale Screen upon admission, quarterly, annually and with significant change as it relates to the assurance of effective on-going assessment of the need for side rails for resident #167 and resident #19, all existing and future residents. The Quality Assurance Coordinator shall complete Audits entitled "Side Rail Rationale Screen Audit" weekly X 1 month, monthly X 1 quarter and quarterly thereafter as to ensure accurate completion of the "Side Rail Rationale Screen" upon admission, quarterly,	

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F 221	Continued From page 4 covering wrapped around the bar at the top of the rail, the center bar and the bottom rail. The resident's right leg was observed to be leaning against the right side rail. An interview was conducted on 10/05/2017 at 11:53 AM with the Resident #167's family member. The family member was in the resident's room during the interview. The family member indicated she visited the resident daily. Resident #167's family member indicated the right full side rail was on the resident's bed upon admission to the facility. The family member stated the resident was usually very busy and moved around in the bed. The family member indicated the resident often put his feet, legs and sometimes his arms through the spaces in the side rail. The family member indicated the resident had some bruises in the past which she and the staff felt were from the rail. The family member stated the resident did not use the rails to position himself. The family member stated the rail was probably there to keep him from falling out of the bed. During the interview the resident started moving his legs toward the rail and wedged his right knee in the space between the center and lower bar. The resident's family member walked to the right side of the bed and told the resident he needed to be still. The family member moved his knee out of the rail space. An interview was conducted with Nurse #2 on 10/5/2017 at 2:46 PM. Nurse #2 was the nurse on duty the evening of 6/27/2017 and verified she was the nurse who wrote the note on 6/27/2017. Nurse #2 stated she worked with the Resident #167 five days a week on the evening shift. Nurse #2 reported the resident is very agitated at times and will flail his limbs in the air at times when he	F 221	annually and with significant change for each resident. The Director of Nursing shall be responsible for implementing the acceptable plan of correction and shall be completed no later than 10/28/2017	

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is agitated. Nurse #2 indicated since the resident was capable of moving his extremities, he was physically capable of getting his limbs caught in the spaces between the bars of the side rail. Nurse #2 indicated the resident continued to require frequent monitoring due to his severe cognition impairment and the inability to follow/understand directions. Nurse #2 also indicated since there was only 1 full side rail, it was not considered a restraint.

An interview was conducted with Nursing Assistant (NA) #2 on 10/5/2017 at 2:58 PM. NA #2 indicated she worked with Resident #167 often and was familiar with his care. NA #2 indicated the resident would often get his feet through the spaces in the side rail and she would have to remove them. NA #2 stated he would also position his right knee in the space on the bottom of the rail and she would have to get it out. NA#2 indicated usually when his right knee was caught in the space he would yell because he would be unable to shift in bed and that agitated him. NA #2 indicated the resident was severely cognitively impaired and was unable to follow directions.

An interview was conducted with MDS Nurse #3 on 10/05/2017 at 3:11 PM. MDS Nurse # 3 indicated she completed the last assessment on Resident # 167 on 8/2/2017. MDS Nurse #3 said she assessed the rail to be safe for the resident and promoted independence, even though he was severely cognitively impaired. MDS Nurse #3 indicated the full rail was not a restraint because it was an enabler and the resident used it for positioning. MDS Nurse #3 further indicated the rail was not coded on the MDS because it was not considered a restraint.

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An interview was conducted with the Assistant Director of Nursing (ADON) on 10/5/2017 at 3:20 PM. The ADON indicated he was familiar with Resident #167 and recalled instances when the resident would have new bruised areas. The ADON indicated investigations were conducted, and the facility and the resident's family member concluded the bruises were from the resident hitting his limbs on the bars of the side rail. The ADON stated he was familiar with the resident, and the resident would flail around in bed when he was agitated. The ADON indicated since there was only 1 full rail on the bed, it was not considered a restraint.

2-Record review revealed resident #19 was admitted to the facility on 12/11/2012 with diagnoses which included Dementia, Anxiety Disorder and functional Quadriplegia.

Record review revealed a Side Rail Rationale Screen assessment dated 7/11/2016 for Resident #19. The resident was assessed as non-ambulatory with an alteration in safety awareness due to cognition. The assessment screen indicated the resident demonstrated difficulty moving to a sitting position, difficulty with balance and poor trunk control, had a history of falls, and was on medications which required increased safety precautions. The assessment screen indicated the resident could not voluntarily get out of bed due to physical limitations, and the side rail was used for positioning and back support. The assessment form indicated side rails were indicated and served as an enabler which promoted independence. The form further indicated the resident expressed a desire to have side rails used while in bed.

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Record review revealed the last comprehensive (Significant Change) Minimum Data Set (MDS) dated 12/15/2016 and the most recent quarterly MDS dated 7/14/2017 indicated the resident was significantly cognitively impaired, rarely/never understood, and severely impaired for decision making. The MDS indicated the resident required total assistance for all activities of daily living (ADLs), and restraints were not used.

The Care Area Assessment (CAA) dated 12/15/2016 indicated the resident was at a risk for falls and was significantly and severely cognitively impaired. The CAA indicated falls and cognition would trigger to the care plan.

Record review revealed the Care Plan updated 7/17/2017 included problems of the risk for falls due to no personal safety recognition and, the resident's confusion and disorientation with significant compromise to functional abilities and understanding. Interventions included the bed in low position, dependent lift for transfers, mat at bedside, and make frequent positioning checks when resident in bed and noted with agitation.

An Incident/Accident Report dated 10/2/2017 was reviewed and revealed Resident #19 was found by Nursing Assistant (NA) #5 at 9:40 PM with both of her legs caught between the side rails. The report indicated the resident sustained a skin tear to her right lower leg when NA #5 removed the resident's legs from the rail, and treatment was initiated. The report listed the resident's condition before the incident as confused and indicated no restraint was in use. There was no nursing note in the medical record on 10/2/2017 and no note regarding the incident.

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A review of the physician's orders for Resident #19 revealed an order for daily treatment to the left lower leg skin tear dated 10/2/2017 and an order to pad the back side rail on 10/3/2017.

An observation was made of the Resident #19 on 10/5/2017 at 8:10 AM. The resident was observed lying in a low bed with her eyes closed. A full side rail was on the left side of the bed in a raised position. There were 3 horizontal bars on the side rail. The resident was observed lying on her left side facing the full rail.

An interview was conducted with NA #2 on 10/05/2017 at 3:03 PM. NA #2 indicated she worked with Resident #19 regularly. NA #2 revealed the resident would put her feet and legs through the spaces in the rail and between the mattress and the rail when she was agitated. The NA indicated the resident would wiggle all around in the bed. The NA further indicated she removed the resident's feet and legs from the side rail spaces several times and would tell the nurse the resident was agitated.

An interview was conducted with MDS Nurse #1 on 10/05/2017 at 3:10 PM. MDS Nurse #1 verified she completed the Side Rail Rationale Screen assessment dated 7/11/2016 for Resident #19. MDS Nurse #1 indicated the screens were usually updated every quarter and did not know why there was not an updated screen for the resident. MDS Nurse #1 also indicated she did not know why she indicated the resident expressed a desire to have the side rails up because the resident was not capable of expressing that desire, due to her significant decreased cognition. MDS Nurse #1 further indicated the side rail did not promote

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independence for the resident, but she did not consider the rail a restraint.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/5/2017 at 3:20 PM. The ADON indicated the facility Incident/Accident Reports are reviewed daily to evaluate the need for follow up actions. The ADON reported if there were issues with the bed rails, the clinical team would indicate the rails needed to be padded to reduce further risk of injury. The ADON stated the facility looked at each incident on an individual basis. The ADON indicated since there was only 1 full rail on the bed, it was not considered a restraint.

An interview was conducted on 10/5/2017 at 4:07 PM with NA #5. NA #5 stated she went into Resident #19's room after dinner on 10/2/2017 and found the resident turned sideways in bed with her legs criss- crossed and completely through the bottom rail space on the bed rail. NA #5 indicated the resident's legs were stuck and the resident was trying to get them out but could not. The NA stated the right leg was over the top of the left leg, so she pulled the right leg out first, and the resident's right heel scraped over the left lower leg and caused a skin tear. NA #5 stated she immediately notified the nurse after she got the resident out of the rail and situated back in bed.

An interview was conducted with Nurse #4 on 10/5/2017 at 4:15 PM. Nurse #4 indicated she was the nurse on duty for Resident #19 on the evening of 10/2/2017. Nurse #4 revealed NA #5 came to her during the shift and reported the resident's legs were in the rail and when the NA got them out the resident sustained a skin tear.

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Nurse #4 indicated she immediately assessed the resident. Nurse #4 reported the resident was in bed when she entered the room and was in no distress. The resident was noted with a skin tear to her left shin and treatment was initiated. Nurse #4 indicated the resident did not have any other injuries observed. Nurse #4 stated she was unsure why she did not document the incident in the nurse's notes but she did fill out an Incident/Accident report. Nurse #4 indicated the resident did not have any other issues during the shift.

The Administer and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 10/5/2017 at 6:12 PM.

The facility provided a credible allegation of compliance on 10/6/2017. The Allegation of Compliance indicated:

"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;

The process leading to cited deficiency was 1. Resident #167 was diagnosed as having cerebral infarction, dementia and cognitively impaired. He was extensive assist with two person assist, required in bed mobility. He was noted by facility state surveyor during the week of 10-2-17 to have been observed with an uncoded physical restraint/bed rail in place with potential risk for injury at time of observations. Resident #167 noted to be confused and unable to request need or expressed desire for side rail or its intended usage at that time.

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2. Resident #19 was diagnosed has having functional quadriplegia, dementia and depressive disorder. The resident was cognitively impaired. The resident was assessed as being total care, two person assist in bed mobility. She was noted during the week of 10-2-17 to have been observed with an uncoded physical restraint/bed rail in place with the potential risk for injury at time of observations. Resident #19 noted to be confused and unable to request need or expressed desire for side rail or its intended usage at that time.

On October 5th, 2017 the Assistant Director of Nursing and Staff Development Coordinator re-assessed Resident #167 and #19 using the "Side Rail Rationale Screen" assessment tool. The side rails were discontinued and removed by Environmental Services for both Resident #167 and Resident #19's beds.

Resident #167 and Resident #19's care plans were reviewed by the Resident Care Coordinator to ensure safety measures and the level of assistance required for activities of daily living (emphasis on bed mobility and transfer) accurately reflected the resident(s) status.

There were no changes made to the resident care plans updated October 5th, 2017 since safety measures and fall prevention interventions were already in place and remained applicable. There were also no changes in the level of assistance needed as documented in the residents plan of care. The side rails were removed on 10/5/17

"The procedure for implementing the acceptable

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(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
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plan of correction for the specific deficiency cited;

Based on the root cause analysis findings, we determined a more comprehensive side rail-screening process was needed to assist the interdisciplinary team in deciding when side rails would be utilized. This process helped to assure through assessment the purpose of the side rails so that they did not pose safety risks such as entrapment for the resident(s). The process also helped to identify bed rails as physical restraints, particularly in cognitively impaired residents as they were not utilized to treat medical symptoms for these two residents. Individual interventions were implemented based on the reassessment of the two residents. Staff were re-educated on all shifts for the two residents.

"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;

On October 6th, 2017, the Director of Compliance amended the policy entitled "Proper Use of Side Rails" to require completion of the "Side Rail Rationale Screen" upon admission, quarterly, annually and with significant change as it relates to the assurance of effective ongoing assessment of the need for side rails for resident #167 and resident #19.

"The title of the person responsible for implementing the acceptable plan of correction.

The Administrator shall be responsible for implementing all above actions to include an acceptable plan of correction.

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The facility provided a credible allegation of compliance on 10/6/2017 at 6:48 PM. The Allegation of Compliance indicated:

The Credible Allegation was verified by:

1-On 10/5/2017 Resident #167 and Resident #19 were reassessed by the ADON and the Staff Development Coordinator using the Side Rail Rationale Assessment Screens and the side rails were removed for both residents.
Both residents were observed on 10/6/2017 at 8:01 AM in bed without side rails.

2-Documentation of the reassessments for every resident in the facility using the Side Rail Rationale Screen was reviewed by the survey team on 10/6/2017. The assessments were completed by the clinical management team. Side rails which were assessed as a safety hazard were documented as removed. Observations of the residents who were assessed as not appropriate for the side rails per the screening form were observed to have their side rails removed.

3-Documentation of Side Rail Safety Inservicing was reviewed on 10/26/2017 and the inservicing included the safe use of side rails and side rails as restraints when not treating a medical symptom. The inservicing was completed by the facility Staff Development Coordinators.

Interviews were conducted with staff present in the facility on 10/6/2017. The staff interviewed confirmed the recent inservice regarding said rails/restraints/safety/entrapment.

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F 272 SS=J	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1)	F 272		10/28/17

(b) Comprehensive Assessments

(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with

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F 272	Continued From page 15 the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately assess the use of a full side rail as a physical restraint for 2 of 4 residents (Resident #167 and Resident #19). Immediate Jeopardy began on 6/27/2017 when Resident #167 was observed by staff with his legs between the side rail bars. Immediate Jeopardy began on 10/2/2017 for Resident #19 both of the resident's legs were between the side rail bars and required staff assistance to remove. The Immediate Jeopardy was removed on 10/6/2017 at 6:54 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education to ensure monitoring systems are in place that are effective. Findings included: 1-Record review revealed Resident #167 was admitted to the facility on 4/21/2017 with diagnoses which included Cerebral Infarction and	F 272	The process leading to cited deficiency was: 1. Resident #167 was diagnosed as having cerebral infarction, dementia and cognitively impaired. He was extensive assist with two person assist, required in bed mobility. He had 14 day MDS assessment completed by MDS staff member, dated 5-30-17 which failed to code resident with presence of physical restraints/bed rails. Resident also had side rail assessment screen completed by MDS staff member, dated 8-4-17 which failed to accurately assess facility usage of single full side rail. 2. Resident #19 was diagnosed has having functional quadriplegia, dementia and depressive disorder. The resident was cognitively impaired. The resident was assessed as being total care, two person assist in bed mobility. She had a quarterly MDS assessment completed by MDS staff member dated 7-14-17 which failed to accurately code resident with presence of physical restraints/bed rails. Resident also had side rail assessment screen completed by MDS staff member, dated 7-11-16 which failed to accurately assess	

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F 272	Continued From page 16 Anxiety Disorder. Record review revealed Resident #167's Care Plan initiated 4/25/2017 and last updated 9/8/2017 included a problem of the risk for falls due to impaired mobility and severely impaired cognition. Interventions included the bed in low position, dependent lift for transfers, mat at bedside, and give resident verbal reminders not to transfer without assistance. The last comprehensive (Admission) Minimum Data Set (MDS) dated 4/28/2017 and the most recent quarterly assessment dated 8/2/2017 indicated Resident #167 was rarely/never understood, had short and long term memory problems, and was severely impaired for daily decision making. The MDS indicated the resident required extensive to total assistance of 1 to 2 persons with all activities of daily living (ADLs), and had no impairment to upper or lower extremities. The MDS indicated bed rails were not used for the resident. The Care Area Assessment (CAA) dated 4/28/2017 indicated Resident #167 was at a risk for falls and was significantly and severely cognitively impaired. The CAA indicated falls and cognition would trigger to the care plan. Record review of nursing notes revealed a note dated 6/27/2017 at 11:15 PM which reported Resident #167 was awake the entire shift, was agitated and restless and was observed with his legs between the side rail bars frequently during the shift. The note indicated the resident was repositioned numerous times. The note further indicated the nurse would request an order for padded side rails. A physicians order dated	F 272	facility usage of single full side rail and residents ability to indicate expressed desire to have side rails while in bed. The plan for correcting the specific deficiency is as follows: On October 5th, 2017 the Assistant Director of Nursing and Staff Development Coordinator re-assessed Resident #167 and #19 using the Side Rail Rationale Screen assessment tool. The side rails were discontinued and removed by Environmental Services for both Resident #167 and Resident #19□s beds. Resident #167 and #19□s current MDS assessment and Side Rail Rationale Screen were reviewed by Resident Care Coordinator to ensure accuracy of resident assessment with emphasis on section P of the MDS assessment. This review and utilization of the MDS assessment with emphasis on resident #167 and resident #19□s CAA□s helped to accurately assess for the need for physical restraints/bed rails for these residents. 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 is as follows: All residents shall have current MDS assessments and "Side Rail Rational Screen" forms reviewed and/or revised by Nursing Administration staff,(Zoners), as to ascertain the need for restraints/bed rails. All residents with discovered need for bed rail modification or removal shall be reported to environmental services for the correct application or removal of	

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F 272	Continued From page 17 6/28/2107 for the back side rail to be padded was in the medical record. Record review revealed a Side Rail Rationale Screen assessment dated 8/4/17 for Resident #167. The resident was assessed as non-ambulatory with an alteration in safety awareness due to cognition. The assessment screen indicated the resident demonstrated difficulty moving to a sitting position, difficulty with balance and poor trunk control, and was on medications which required increased safety precautions. The assessment screen indicated the side rail was used for positioning and back support, and was indicated for the resident as an enabler which promoted independence. An observation was conducted of the Resident #167 on 10/05/2017 8:53 AM. The resident was observed in bed sleeping. The resident's right leg was observed to be leaning against the right side rail. There was grey colored foam- like thin covering wrapped around the bar at the top of the rail, the center bar and the bottom rail. An interview was conducted on 10/05/2017 at 11:53 AM with Resident #167's family member. The family member was in the resident's room during the interview. The family member indicated she visited the resident daily. The family member stated the resident was usually very busy and moved around in the bed. The family member indicated the resident often put his feet, legs and sometimes his arms through the spaces in the side rail. The family member stated the resident did not use the rails to position himself. The family member stated the rail was probably there to keep him from falling out of the bed. During the interview the resident started moving his legs	F 272	corresponding bed rails. Any existing bed rails shall have the FDA "Hospital Bed System Dimensional and Assessment Guide to Reduce Entrapment for Bed Rail use" completed by Environmental Services for those rails. Additionally, the Nurse Consultant shall educate the Resident Care Coordinator and MDS staff nurses on the definition of restraints and coding guidelines for P0100 using the RAI Manual and education tool Myths and Facts about Side Rails. MDS staff shall utilize education to monitor and complete ongoing MDS assessments and Side Rail Rationale Screen forms of Resident #167, #19, and all existing and future residents so as to ensure continued accuracy of completed assessments as it relates to regulatory requirements. The Staff Development Coordinator shall educate nursing staff as it relates to assessment and utilization for restraint/bed rail application with emphasis on the definition of restraints and bed rails as well as policy entitled "Proper Use of Side Rails." The Quality Assurance Coordinator shall complete Audits entitled "Side Rail Rationale Screen Audit" weekly X 1 month, monthly X 1 quarter and quarterly thereafter as to ensure accurate completion of the "Side Rail Rationale Screen" upon admission, quarterly, annually and with significant change for each resident. The Director of Nursing shall be responsible for implementing the acceptable plan of correction and shall be completed no later than 10/28/2017	

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toward the rail and wedged his right knee in the space between the center and lower bar. The resident's family member walked to the right side of the bed and told the resident he needed to be still. The family member moved his knee out of the rail space.

An interview was conducted with Nurse #2 on 10/5/2017 at 2:46 PM. Nurse #2 was the nurse on duty the evening of 6/27/2017 and verified she was the nurse who wrote the note on 6/27/2017. Nurse #2 stated she worked with the Resident #167 five days a week on the evening shift. Nurse #2 reported the resident is very agitated at times and will flail his limbs in the air at times when he is agitated. Nurse #2 indicated the right side rail was up at all times while the resident was in bed. Nurse #2 indicated she was unsure of the exact reason the rail was utilized for the resident, but she thought it was probably to keep him from rolling off of the bed. Nurse #2 indicated the resident continued to require frequent monitoring due to his severe cognition impairment and the inability to follow/understand directions.

An interview was conducted with Nursing Assistant (NA) #2 on 10/5/2017 at 2:58 PM. NA #2 indicated she worked with Resident #167 often and was familiar with his care. NA #2 indicated the resident would often get his feet through the spaces in the side rail and she would have to remove them. NA #2 stated he would also position his right knee in the space on the bottom of the rail and she would have to get it out. NA#2 indicated usually when his right knee was caught in the space he would yell because he would be unable to shift in bed and that agitated him. NA #2 indicated the resident was severely cognitively impaired and was unable to follow directions.

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An interview was conducted with MDS Nurse #3 on 10/05/2017 at 3:11 PM. MDS Nurse # 3 indicated she completed the last assessment on Resident # 167 on 8/2/2017. MDS Nurse #3 said she assessed the rail to be safe for the resident and promoted independence, even though he was severely cognitively impaired. MDS Nurse #3 indicated the full rail was not a restraint because it was used as an enabler and for positioning. MDS Nurse #3 further indicated the rail was not coded on the MDS because it was not considered or assessed as a restraint.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/5/2017 at 3:20 PM. The ADON stated he was familiar with the resident, and the resident would flail around in bed when he was agitated and the side rail was on the bed as an enabler. The ADON indicated since there was only 1 full rail on the bed, it was not considered a restraint.

2-Record review revealed resident #19 was admitted to the facility on 12/11/2012 with diagnoses which included Dementia, Anxiety Disorder and functional Quadriplegia.

Record review revealed a Side Rail Rationale Screen assessment dated 7/11/2016 for Resident #19. The resident was assessed as non-ambulatory with an alteration in safety awareness due to cognition. The assessment screen indicated the resident demonstrated difficulty moving to a sitting position, difficulty with balance and poor trunk control, had a history of falls, and was on medications which required increased safety precautions. The assessment

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screen indicated the resident could not voluntarily get out of bed due to physical limitations, and the side rail was used for positioning and back support. The assessment form indicated side rails were indicated and served as an enabler which promoted independence. The form further indicated the resident expressed a desire to have side rails used while in bed.

Record review revealed the last comprehensive (Significant Change) Minimum Data Set (MDS) dated 12/15/2016 and the most recent quarterly MDS dated 7/14/2017 indicated the resident was significantly cognitively impaired, rarely/never understood, and severely impaired for decision making. The MDS indicated the resident required total assistance for all activities of daily living (ADLs), and restraints were not used.

The Care Area Assessment (CAA) dated 12/15/2016 indicated the resident was at a risk for falls and was significantly and severely cognitively impaired. The CAA indicated falls and cognition would trigger to the care plan.
Record review revealed the Care Plan updated 7/17/2017 included problems of the risk for falls due to no personal safety recognition and, the resident's confusion and disorientation with significant compromise to functional abilities and understanding. Interventions included the bed in low position, dependent lift for transfers, mat at bedside, and make frequent positioning checks when resident in bed and noted with agitation.

An Incident/Accident Report dated 10/2/2017 was reviewed and revealed the resident was found by Nursing Assistant (NA) #5 at 9:40 PM with both of her legs caught between the side rails. The report indicated the resident sustained a skin tear to her

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right lower leg when NA #5 removed the resident's legs from the rail, and treatment was initiated. The report listed the resident's condition before the incident as confused and indicated no restraint was in use. There was no nursing note in the medical record on 10/2/2017 and no note regarding the incident.

A review of the physician's orders revealed an order for daily treatment to the left lower leg skin tear dated 10/2/2017 and an order to pad the back side rail on 10/3/2017.

An observation was made of the resident on 10/5/2017 at 8:10 AM. The resident was observed lying in a low bed with her eyes closed. A full side rail was on the left side of the bed in a raised position. There were 3 horizontal bars on the side rail. There was grey colored foam- like thin covering wrapped around the bar at the top of the rail, the center bar and the bottom rail. The resident was observed lying on her left side facing the full rail.

An interview was conducted with NA #2 on 10/05/2017 at 3:03 PM. NA #2 indicated she worked with Resident #19 regularly. NA #2 revealed the resident would put her feet and legs through the spaces in the rail and between the mattress and the rail when she was agitated. The NA indicated the resident would wiggle all around in the bed. The NA further indicated she removed the resident's feet and legs from the side rail spaces several times and would tell the nurse the resident was agitated.

An interview was conducted with MDS Nurse #1 on 10/05/2017 at 3:10 PM. MDS Nurse #1 verified she completed the Side Rail Rationale

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Screen assessment dated 7/11/2016 for Resident #19. MDS Nurse #1 indicated the screens were usually updated every quarter and did not know why there was not an updated screen for the resident. MDS Nurse #1 also indicated she did not know why she indicated the resident expressed a desire to have the side rails up because the resident was not capable of expressing that desire, due to her significant decreased cognition. MDS Nurse #1 further indicated the side rail did not promote independence for the resident, but she did not consider the rail a safety hazard. The MDS Nurse #1 further indicated the side rail did not meet the definition of a restraint for the resident so therefore was not assessed as a restraint.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/5/2017 at 3:20 PM. The ADON indicated the facility Incident/Accident Reports are reviewed daily to evaluate the need for follow up actions. The ADON stated the facility looked at each incident on an individual basis. The ADON indicated since there was only 1 full rail on the bed, it was not assessed as a restraint.

An interview was conducted on 10/5/2017 at 4:07 PM with NA #5. NA #5 stated she went into Resident #19's room after dinner on 10/2/2017 and found the resident turned sideways in bed with her legs criss- crossed and completely through the bottom rail space on the bed rail. NA #5 indicated the resident's legs were stuck and the resident was trying to get them out but could not. The NA stated the right leg was over the top of the left leg, so she pulled the right leg out first, and the resident's right heel scraped over the left lower leg and caused a skin tear. NA #5 stated

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she immediately notified the nurse after she got the resident out of the rail and situated back in bed.

An interview was conducted with Nurse #4 on 10/5/2017 at 4:15 PM. Nurse #4 indicated she was the nurse on duty for Resident #19 on the evening of 10/2/2017. Nurse #4 revealed NA #5 came to her during the shift and reported the resident's legs were in the rail and when the NA got them out the resident sustained a skin tear. Nurse #4 indicated she immediately assessed the resident. Nurse #4 reported the resident was in bed when she entered the room and was in no distress. The resident was noted with a skin tear to her left shin and treatment was initiated. Nurse #4 indicated the resident did not have any other injuries observed. Nurse #4 stated she was unsure why she did not document the incident in the nurse's notes but she did fill out an Incident/Accident report. Nurse #4 indicated the resident did not have any other issues during the shift.

The Administer and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 10/5/2017 at 6:12 PM.

The facility provided a credible allegation of compliance on 10/6/2017 at 6:48 PM. The Allegation of Compliance indicated:

"The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;

The process leading to cited deficiency was 1. Resident #167 was diagnosed as having cerebral infarction, dementia and cognitively

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impaired. He was extensive assist with two person assist, required in bed mobility. He had 14 day MDS assessment completed by MDS staff member, dated 5-30-17 which failed to code resident with presence of physical restraints/bed rails. Resident also had side rail assessment screen completed by MDS staff member, dated 8-4-17 which failed to accurately assess facility usage of single full side rail. 2. Resident #19 was diagnosed has having functional quadriplegia, dementia and depressive disorder. The resident was cognitively impaired. The resident was assessed as being total care, two person assist in bed mobility. She had a quarterly MDS assessment completed by MDS staff member dated 7-14-17 which failed to accurately code resident with presence of physical restraints/bed rails. Resident also had side rail assessment screen completed by MDS staff member, dated 7-11-16 which failed to accurately assess facility usage of single full side rail and residents ability to indicate expressed desire to have side rails while in bed.

"The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

On October 5th, 2017 the Assistant Director of Nursing and Staff Development Coordinator re-assessed Resident #167 and #19 using the "Side Rail Rationale Screen" assessment tool. The side rails were discontinued and removed by Environmental Services for both Resident #167 and Resident #19's beds.

Resident #167 and #19's current MDS assessment and "Side Rail Rationale Screen" were reviewed by Resident Care Coordinator to ensure accuracy of resident assessment with

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emphasis on section P of the MDS assessment. This review and utilization of the MDS assessment with emphasis on resident #167 and resident #19's CAA's helped to accurately assess for the need for physical restraints/bed rails for these residents.

"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

On 10-6-17 The Nurse Consultant educated the Resident Care Coordinator and MDS staff nurses on the definition of restraints and coding guidelines for P0100 using the RAI Manual and education tool "Myths and Facts about Side Rails." MDS staff shall utilize education to monitor and complete ongoing MDS assessments and "Side Rail Rationale Screen" of Resident #167 and #19 so as to ensure continued accuracy of completed assessments as it relates to regulatory requirements.

"The title of the person responsible for implementing the acceptable plan of correction.

The Administrator shall be responsible for implementing all above actions to include an acceptable plan of correction.

The Credible Allegation was verified by:
1-On 10/5/2017 Resident #167 and Resident #19 were reassessed by the ADON and the Staff Development Coordinator using the Side Rail Rationale Assessment Screens and the side rails were removed for both residents.

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F 272	Continued From page 26 Both residents were observed on 10/6/2017 at 8:01 AM in bed without side rails. 2-Documentation of the reassessments for every resident in the facility using the Side Rail Rationale Screen was reviewed by the survey team on 10/6/2017. Side rails which were assessed as a safety hazard were documented as removed. Observations of the residents who were assessed as not appropriate for the side rails per the screening form were observed to have their side rails removed. 3-Documentation of Side Rail Safety Inservicing was reviewed on 10/6/2017 and the inservicing included the risk of entrapment for residents with unsafe side rails. Documentation of the Nurse Consultant education for the Resident Care Coordinator and MDS staff nurses was reviewed on the definition of restraints and coding guidelines for P0100 using the RAI Manual and education tool "Myths and Facts about Side Rails." Interviews were conducted with staff present in the facility on 10/6/2017. The staff interviewed confirmed the recent inservice regarding said rail safety/entrapment.	F 272		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered	F 280		10/28/17

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F 280	Continued From page 27 plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans	F 280		

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F 280	Continued From page 28 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff and family interviews and record review, the facility failed to include a nursing assistant in the interdisciplinary	F 280	The Process leading to the cited deficiency was: Resident #45 which was noted to have diagnoses of hip fracture,	

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care team planning for one of two residents reviewed for care plan meetings (Resident #45). Findings included:

A review of the medical record revealed Resident #45 was admitted 5/8/2017 with diagnoses of right hip fracture, acute pain, anxiety and dementia.

The Quarterly Minimum Data Set (MDS) dated 10/4/2017 noted Resident #45 was cognitively intact and needed extensive assistance all Activities of Daily Living (ADLs).

A review of care plan meeting sign in sheets revealed two care plan meetings were documented on 5/31/2017 and 8/31/2017, with no nursing assistant noted to be in attendance.

On 10/5/2017 at 2:50 PM in an interview, the MDS co coordinator read who was in the care plan meeting, and a nursing assistant was not noted to be there. The MDS coordinator stated she was not aware of that regulation.

On 10/5/2017 at 3:43 PM in an interview, Nursing Assistant (NA) #1 stated she had never been asked to be part of care planning.

In an interview on 10/5/2017 at 3:55 PM, NA #2 stated she had never been part of the care planning team.

On 10/6/2017 at 11:30 AM, NA #3 stated she had never been asked to be part of a care planning team.

In an interview on 10/6/2017 at 11:35 PM, NA #4 stated she had never been part of a care planning acute pain, anxiety and dementia had care plan conferences completed on dates 05/03/2017 and 08/31/2017. Theses meeting were noted by facility state surveyor on 10/04/2017 to not have included a nursing assistant directly related to resident #45's care in attendance. Nursing assistants interviewed by state surveyor on 10/05/2017 and 10/06/2017 were noted to not have been asked to participate in care planning nor been part of the care planning team.
The plan of correcting this deficiency shall be to update the care plan for resident #45 to include a nursing assistant directly involved for the care of resident #45. The procedure for completing this plan shall be that the Resident Care Coordinator and/or her designee invited a nursing assistant directly involved in the care for resident #45 to a multidisciplinary care plan conference. The nursing assistant's attendance shall be recorded on the "Care Plan Conference sign in" form. The Resident Care Coordinator and MDS staff nurses shall receive education by the nurse consultant focusing on RAI Manual instruction and planning of resident care, to include concentration of inclusion of nursing assistants in the care planning conference. Nursing staff shall receive education by the Staff Development Coordinator as it relates to F 483.21(ii) (C) A comprehensive care plan must be prepared by an interdisciplinary team that includes a nurse aide with responsibility for the resident. The monitoring procedure to ensure that the plan of

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F 280	Continued From page 30 team. On 10/6/2017 at 11:40 AM, in an interview, NA #5 stated she had never been part of a care planning team. An interview with the Administrator was conducted on 10/6/2017 at 12:10 PM. The Administrator stated his expectation was the NAs would be involved with the care planning.	F 280	correction is effective and that the specific deficiency cited remains corrected and in compliance with regulatory requirements shall be that the Quality Assurance Coordinator will conduct audits entitled "Nursing Assistant Care Plan involvement Audit." These audits shall be completed weekly X 1 month, monthly X 1 quarter, and quarterly thereafter and should monitor for the involvement of nursing assistants which are directly related to resident care for whom care plans are being completed. This monitoring shall utilize the "Care Plan Conference Sign In" form and the "CNA Care Plan Input for Resident Care Conference" form. The Director of Nursing shall be responsible for implementing the acceptable plan of correction and shall be completed no later than 10/28/2017	
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	F 323		10/28/17

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F 323	Continued From page 31 to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (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 staff interviews, the facility failed to identify a full side rail as an accident hazard for 2 of 4 residents (Resident #167 and Resident #19) when Resident #167 was observed by staff with his legs entrapped between the side rail bars and required staff assistance to remove his legs from the side rail space and failing to implement interventions to prevent it from happening again and for Resident #19 who was observed with both legs entrapped between the side rail bars which required staff assistance to remove her legs and sustained a skin tear while staff removed her legs and failing to implement interventions to prevent it from happening again. Immediate Jeopardy began on 6/27/2017 when Resident #167 was observed by staff with his legs between the side rail bars. Immediate Jeopardy began on 10/2/2017 for Resident #19 both of the resident's legs were between the side rail bars and required staff assistance to remove. The Immediate Jeopardy was removed on 10/6/2017 at 6:54 PM when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity	F 323	The process leading to cited deficiency was: 1. Resident #167 was diagnosed as a having cerebral infarction, dementia and cognitively impaired. He was extensive assist with two person assist required in bed mobility. He was noted to be anxious and restless moving body/legs across bed. Resident found with both legs in between side rail on numerous occasions on 6/27/17. 2. Resident # 19 was diagnosed has having functional quadriplegia, dementia and depressive disorder. The resident was cognitively impaired. The resident was assessed as being total care two person assist in bed mobility. She was found to have both legs between the side-rail on 10/2/17. While repositioning resident to remove legs from side-rail by C.N.A., a skin tear to the right lower leg was sustained. The plan of correcting the specific deficiency included as follows: On October 5th, 2017 the Assistant Director of Nursing and Staff Development Coordinator re-assessed Resident #167	

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F 323	Continued From page 32 level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education to ensure monitoring systems are in place that are effective. Findings included: 1. Record review revealed resident #167 was admitted to the facility on 4/21/2017 with diagnoses which included Cerebral Infarction and Anxiety Disorder. Record review revealed the Care Plan initiated on 4/25/2017 included a problem of the risk for falls due to impaired mobility and severely impaired cognition. Interventions included the bed in low position, dependent lift for transfers, mat at bedside, and give resident verbal reminders not to transfer without assistance. The last comprehensive (Admission) Minimum Data Set (MDS) dated 4/28/2017 and the most recent quarterly assessment dated 8/2/2017 indicated the Resident #167 was rarely/never understood, had short and long term memory problems, and was severely impaired for daily decision making. The MDS indicated the resident required extensive to total assistance of 1 to 2 persons with all activities of daily living (ADLs) and bed mobility, required total assistance for transfers and had no impairment to upper or lower extremities. The MDS indicated bed rails were not used for the resident. The Care Area Assessment (CAA) dated 4/28/2017 indicated Resident #167 was at a risk for falls and was significantly and severely cognitively impaired. The CAA indicated falls and cognition would trigger to the care plan.	F 323	and #19 using the Side Rail Rationale Screen assessment tool. The side rails were discontinued and removed by Environmental Services for both Resident #167 and Resident #19□s beds. Resident #167 and Resident #19□s care plans were reviewed by the Resident Care Coordinator to ensure safety measures and the level of assistance required for activities of daily living (emphasis on bed mobility and transfer) accurately reflected the resident(s) status. There were no changes made to the resident care plans since safety measures and fall prevention interventions were already in place and remained applicable. There were also no changes in the level of assistance needed as documented in the residents plan of care. The side rails were removed on 10/5/17 and the care plan was updated on the same date. The procedure for implementing the acceptable plan of correction for the specific deficiency cited included as follows: Based on the root cause analysis findings, we determined a more comprehensive side rail-screening process was needed to assist the interdisciplinary team in deciding when side rails would be utilized. This process helped to assure through assessment the purpose of the side rails so that they did not pose safety risks such as entrapment for the resident(s). The process also help to identify bed rails as physical restraints, particularly in cognitively impaired residents as they were not utilized to treat medical symptoms for these two residents. Individual interventions were	

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F 323	Continued From page 33 Record review of nursing notes revealed a note dated 6/27/2017 at 11:15 PM which reported Resident #167 was awake the entire shift, was agitated and restless and was observed with his legs between the side rail bars frequently during the shift. The note indicated the resident was repositioned numerous times. The note further indicated the nurse would request an order for padded side rails. A physicians order dated 6/28/2017 for the back side rail to be padded was in the medical record. Record review revealed a Side Rail Rationale Screen assessment dated 8/4/17 for Resident #167. The resident was assessed as non-ambulatory with an alteration in safety awareness due to cognition. The assessment screen indicated the resident demonstrated difficulty moving to a sitting position, difficulty with balance and poor trunk control, and was on medications which required increased safety precautions. The assessment screen indicated the side rail was used for positioning and back support, and was indicated for the resident as an enabler which promoted independence. An observation was conducted of Resident #167 on 10/05/2017 8:53 AM. The resident was observed in bed sleeping. The head of the bed was raised approximately 35 degrees. A full side rail was on the right side of the bed in a raised position. There were 3 horizontal bars on the side rail. There was a 4 inch space between the between the center bar and the top bar of the rail and same amount of space between the center bar and the lower bar on the side rail. There was grey colored foam-like thin covering wrapped around the bar at the top of the rail, the center bar and the bottom rail. The foam padding did not	F 323	implemented based on the reassessment of the two residents. Staff were re-educated on all shifts for these two residents and for all existing and future residents. Education included direct instruction from CMS's RAI manual with emphasis on section (P)Restraints and Alarms and the definitions of restraints as well as Bed Rails and facility policy "Proper Use of Side Rails." The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory is: On October 6th, 2017, the Director of Compliance amended the policy entitled Proper Use of Side Rails to require completion of the Side Rail Rationale Screen upon admission, quarterly, annually and with significant change as it relates to the assurance of effective on-going assessment of the need for side rails for resident #167 and resident #19, all existing and future residents. The Quality Assurance Coordinator shall complete Audits entitled "Side Rail Rationale Screen Audit" weekly X 1 month, monthly X 1 quarter and quarterly thereafter as to ensure accurate completion of the "Side Rail Rationale Screen" upon admission, quarterly, annually and with significant change for each resident. Any existing bed rails shall be evaluated by environmental services using the FDA "Hospital Bed System Dimensional and Assessment Guide to Reduce Entrapment for Bed Rail Usage." Any existing bed rails deemed unsafe or that pose safety or entrapment risks shall	

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F 323	Continued From page 34 lessen the amount of space between the horizontal bars on the side rail. The Resident #167's resident's right leg was observed to be leaning against the right side rail. An interview was conducted on 10/05/2017 at 11:53 AM with Resident #167's family member. Resident #167's family member was in the resident's room during the interview. The family member indicated she visited the resident daily and was with Resident #167 when he was admitted to the facility from the hospital. Resident #167's family member indicated the right full side rail was on the resident's bed upon admission to the facility. The family member stated the resident was usually very busy and moved around in the bed. The family member indicated the resident often put his feet, legs and sometimes his arms through the spaces in the side rail. The family member indicated Resident #167 had some bruises in the past which she and the staff felt were from the rail. The family member reported the staff put the covering on the rail bars a few weeks ago to help with the rail being so hard if he hit it, but the covering didn't make the space between the bars any smaller. The family member stated the resident did not use the rails to position himself. The family member further stated the rail was probably there to keep him from falling out of the bed. During the interview the resident started moving his legs toward the rail and wedged his right knee in the space between the center and lower bar. The resident's family member walked to the right side of the bed and told the resident he needed to be still. The family member moved his knee out of the rail space. An interview was conducted with Nurse #2 on	F 323	be disposed of immediately. The Director of Nursing shall be responsible for implementing the acceptable plan of correction and shall be completed no later than 10/28/2017	

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10/5/2017 at 2:46 PM. Nurse #2 was the nurse on duty the evening of 6/27/2017 and verified she was the nurse who wrote the note on 6/27/2017. Nurse #2 stated she worked with Resident #167 five days a week on the evening shift. Nurse #2 reported the resident is very agitated at times and will flail his limbs in the air at times when he is agitated. Nurse #2 indicated she requested an order for his side rail to be padded to assist with the possibility of injury. Nurse #2 indicated padding the bars on the rail did not lessen the risk for entrapment. Nurse #2 indicated since the resident was capable of moving his extremities, he was physically capable of getting his limbs caught in the spaces between the bars of the side rail. Nurse #2 indicated the resident continued to require frequent monitoring due to his severe cognition impairment and the inability to follow/understand directions.

An interview was conducted with Nurse Aide (NA) #2 on 10/5/2017 at 2:58 PM. NA #2 indicated she worked with Resident #167 often and was familiar with his care. NA #2 indicated the resident would often get his feet through the spaces in the side rail and she would have to remove them. NA #2 stated he would also position his right knee in the space on the bottom of the rail and she would have to get it out. NA#2 indicated usually when his right knee was caught in the space he would yell because he would be unable to shift in bed and that agitated him. NA #2 indicated the resident was severely cognitively impaired and was unable to follow directions.

An interview was conducted with MDS Nurse #3 on 10/05/2017 at 3:11 PM. MDS Nurse # 3 indicated she completed the last assessment on Resident #167 on 8/2/2017. MDS Nurse #3 said

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the right side rail was on Resident #167's bed upon his admission to the facility and she assessed the rail to be safe for the resident and promoted independence, even though he was severely cognitively impaired.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/5/2017 at 3:20 PM. The ADON indicated he was familiar with Resident #167 and recalled instances when the resident would have new bruised areas. The ADON indicated investigations were conducted, and the facility and the resident's family member concluded the bruises were from the resident hitting his limbs on the bars of the side rail. The ADON stated he was familiar with the resident, and the resident would flail around in bed when he was agitated. The ADON reported if there were issues with the bed rails, the clinical team would indicate the rails needed to be padded to reduce further risk of injury and the rails would be covered on the day the decision was made. The ADON indicated when the rails were padded, a thin foam-like covering was placed on the horizontal bars of the side rails. The ADON further indicated when the bed rails were padded, the spaces between the bars of the rails were not affected. The ADON stated the facility looked at each incident on an individual basis.

2. Record review revealed Resident #19 was admitted to the facility on 12/11/2012 with diagnoses which included Dementia, Anxiety Disorder and functional Quadriplegia.

Record review revealed a Side Rail Rationale Screen assessment dated 7/11/2016 for Resident

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#19. The resident was assessed as non-ambulatory with an alteration in safety awareness due to cognition. The assessment screen indicated the resident demonstrated difficulty moving to a sitting position, difficulty with balance and poor trunk control, had a history of falls, and was on medications which required increased safety precautions. The assessment screen indicated the resident could not voluntarily get out of bed due to physical limitations, and the side rail was used for positioning and back support. The assessment form indicated side rails were indicated and served as an enabler which promoted independence. The form further indicated the resident expressed a desire to have side rails used while in bed.

Record review revealed the last comprehensive (significant change) Minimum Data Set (MDS) dated 12/15/2016 and the most recent quarterly MDS dated 7/14/2017 indicated the Resident #19 was significantly cognitively impaired, rarely/never understood, and severely impaired for decision making. The MDS indicated the resident required total assistance for all activities of daily living (ADLs), and bed rails were not used.

The Care Area Assessment (CAA) dated 12/15/2016 indicated Resident #19 was at a risk for falls and was significantly and severely cognitively impaired. The CAA indicated falls and cognition would trigger to the care plan.
Record review revealed the Care Plan updated 7/17/2017 included problems of the risk for falls due to no personal safety recognition and, Resident #19's confusion and disorientation with significant compromise to functional abilities and understanding. Interventions included the bed in low position, dependent lift for transfers, mat at

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bedside, and make frequent positioning checks when resident in bed and noted with agitation.

An Incident/Accident Report dated 10/2/2017 was reviewed and revealed Resident #19 was found by Nurse Aide (NA) #5 at 9:40 PM with both of her legs caught between the side rails. The report indicated the resident sustained a skin tear to her right lower leg when NA #5 removed the resident's legs from the rail, and treatment was initiated. The report listed the resident's condition before the incident as confused and indicated no restraint was in use. There was no nursing note in the medical record on 10/2/2017 and no note regarding the incident.

A review of the physician's orders revealed an order for daily treatment to the left lower leg skin tear dated 10/2/2017 and an order to pad the back side rail on 10/3/2017.

An observation was made of Resident #19 on 10/5/2017 at 8:10 AM. The resident was observed lying in a low bed with her eyes closed. A full side rail was on the left side of the bed in a raised position. There were 3 horizontal bars on the side rail. There was a 4 inch space between the center bar and the top bar of the rail and same amount of space between the center bar and the lower bar on the side rail. There was grey colored foam-like thin covering wrapped around the bar at the top of the rail, the center bar and the bottom rail. The foam padding did not lessen the amount of space between the horizontal bars on the side rail. The resident was observed lying on her left side facing the full rail.

An interview was conducted with NA #2 on 10/05/2017 at 3:03 PM. NA #2 indicated she

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worked with Resident #19 regularly. NA #2 revealed the resident would put her feet and legs through the spaces in the rail and between the mattress and the rail when she was agitated. The NA indicated the resident would wiggle all around in the bed. The NA further indicated she removed the resident's feet and legs from the side rail spaces several times and would tell the nurse the resident was agitated.

An interview was conducted with MDS Nurse #1 on 10/05/2017 at 3:10 PM. MDS Nurse #1 verified she completed the Side Rail Rationale Screen assessment dated 7/11/2016 for Resident #19. MDS Nurse #1 indicated the screens were usually updated every quarter and did not know why there was not an updated screen for the resident. MDS Nurse #1 also indicated she did not know why she indicated the resident expressed a desire to have the side rails up because the resident was not capable of expressing that desire, due to her significant decreased cognition. MDS Nurse #1 further indicated the side rail did not promote independence for the resident, but she did not consider the rail a safety hazard.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/5/2017 at 3:20 PM. The ADON indicated the facility Incident/Accident Reports were reviewed daily to evaluate the need for follow up actions. The ADON reported if there were issues with the bed rails, the clinical team would indicate the rails needed to be padded to reduce further risk of injury. The ADON indicated when the rails were padded, a thin foam-like covering was placed on the horizontal bars of the side rails and Resident #19's were padded on 10/3/2017. The ADON

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further indicated when the bed rails were padded, the spaces between the bars of the rails were not affected. The ADON stated the facility looked at each incident on an individual basis.

An interview was conducted on 10/5/2017 at 4:07 PM with NA #5. NA #5 stated she went into Resident #19's room after dinner on 10/2/2017 and found the resident turned sideways in bed with her legs criss-crossed and completely through the bottom rail space on the bed rail. NA #5 indicated the resident's legs were stuck and the resident was trying to get them out but could not. The NA stated the right leg was over the top of the left leg, so she pulled the right leg out first, and the resident's right heel scraped over the left lower leg and caused a skin tear. NA #5 stated she immediately notified the nurse after she got the resident out of the rail and situated back in bed.

An interview was conducted with Nurse #4 on 10/5/2017 at 4:15 PM. Nurse #4 indicated she was the nurse on duty for Resident #19 on the evening of 10/2/2017. Nurse #4 revealed NA #5 came to her during the shift and reported the resident's legs were in the rail and when the NA got them out the resident sustained a skin tear. Nurse #4 indicated she immediately assessed the resident. Nurse #4 reported the resident was in bed when she entered the room and was in no distress. The resident was noted with a skin tear to her left shin and treatment was initiated. Nurse #4 indicated the resident did not have any other injuries observed. Nurse #4 stated she was unsure why she did not document the incident in the nurse's notes but she did fill out an Incident/Accident report. Nurse #4 indicated the resident did not have any other issues during the

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shift.

The Administer and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 10/5/2017 at 6:12 PM.

The facility provided a credible allegation of compliance on 10/6/2017 at 6:48 PM. The Allegation of Compliance indicated:

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;

The process leading to cited deficiency was 1. Resident #167 was diagnosed as a having cerebral infarction, dementia and cognitively impaired. He was extensive assist with two person assist required in bed mobility. He was noted to be anxious and restless moving body/legs across bed. Resident found with both legs in between side rail on numerous occasions on 6-27-17.
2. Resident # 19 was diagnosed has having functional quadriplegia, dementia and depressive disorder. The resident was cognitively impaired. The resident was assessed as being total care two person assist in bed mobility. She was found to have both legs between the side rails on 10-2-17. While repositioning resident to remove legs from side rail by C.N.A., a skin tear to the right lower leg was sustained.

On October 5th, 2017 the Assistant Director of Nursing and Staff Development Coordinator re-assessed Resident #167 and #19 using the "Side Rail Rationale Screen" assessment tool. The side rails were discontinued and removed by

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Environmental Services for both Resident #167 and Resident #19's beds.

Resident #167 and Resident #19's care plans were reviewed by the Resident Care Coordinator to ensure safety measures and the level of assistance required for activities of daily living (emphasis on bed mobility and transfer) accurately reflected the resident(s) status. There were no changes made to the resident care plans since safety measures and fall prevention interventions were already in place and remained applicable. There were also no changes in the level of assistance needed as documented in the residents' plan of care. The side rails were removed on 10/5/17 and the care plan was updated on the same date.

"The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

Based on the root cause analysis findings, we determined a more comprehensive side rail-screening process was needed to assist the interdisciplinary team in deciding when side rails would be utilized. The process helped to assure through assessment the purpose of the side rails so that they did not pose safety risks such as entrapment for the resident(s). Individual interventions were implemented based on the reassessment of the two residents. Staff were re-educated on all shifts for the two identified residents.

"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;

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On 10/6/17 the FDA "Hospital Bed System Dimensional and Assessment Guide to Reduce Entrapment" for bed rail use was completed by Environmental Services for these two residents. The Social Worker notified the facility residents and responsible party/ family as to this process.

"The title of the person responsible for implementing the acceptable plan of correction.
The Administrator shall be responsible for implementing all above actions to include an acceptable plan of correction.

The Credible Allegation was verified by:
1-On 10/5/2017 Resident #167 and Resident #19 were reassessed by the ADON and the Staff Development Coordinator using the Side Rail Rationale Assessment Screens and the side rails were removed for both residents.
Both residents were observed on 10/6/2017 at 8:01 AM in bed without side rails.
2-Documentation of the reassessments for every resident in the facility using the Side Rail Rationale Screen was reviewed by the survey team on 10/6/2017.
Side rails which were assessed as a safety hazard were documented as removed.
Observations of the residents who were assessed as not appropriate for the side rails per the screening form were observed to have their side rails removed.
3-Documentation of Side Rail Safety Inservicing was reviewed on 10/6/2017 and the inservicing included the risk of entrapment for residents with unsafe side rails.
Interviews were conducted with staff present in the facility on 10/6/2017. The staff interviewed confirmed the recent inservice regarding said rail

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