| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| RIVERPOINT CREST NURSING AND REHABILITATION CENTER | 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563 |

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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 12/2/2019 through 12/5/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 29LM11. | E 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews the facility failed to accurately code the Minimum Data Set (MDS) for hospice care (Resident # 88) and the use of antipsychotics (Resident # 38) for 2 of 40 residents reviewed for MDS accuracy.<br><br>Findings included:<br><br>1.Resident # 88 was admitted to the facility on 3/23/2017 with diagnoses which included diabetes mellitus, dementia with behavior disturbances, and alzheimer's disease. Resident # 88 expired on 10/18/2019.<br><br>The latest quarterly MDS dated 8/6/2019 showed the box was not marked to indicate Resident #88 received hospice care.<br><br>A physician order dated 6/25/2018 revealed discontinue comfort care and add hospice care.<br><br>The initial skilled Hospice Nurse visit dated 6/25/2018 revealed Resident # 88 was to be seen twice a week by the nurse and five times a week | F 641 | Riverpoint Crest Nursing and Rehabilitation Center acknowl-edges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.<br><br>Riverpoint Crest Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Riverpoint Crest Nursing and Rehabilitation Center re-serves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. | 12/23/19 |

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

Electronically Signed | 12/23/2019

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| F 641 | Continued From page 1<br>by the nurse aide.<br><br>The care plan dated 6/27/2018 and revised on 10/18/2019 revealed a plan which focused on hospice care due to a progressive disease process.<br><br>The Hospice Plan of care dated 7/18/2019 revealed Resident # 88 was recertified for hospice services from 7/18/2019 through 9/15/2019.<br><br>The hospice skilled nursing note dated 7/30/2019 revealed Resident # 88 was seen by the nurse with interventions planned for the next week visit.<br><br>During an interview with the Nurse Aide # 3 on 12/4/2019 at 1:00 pm, she stated the Hospice Nurse and Nurse Aide both came to the facility and worked with Resident # 88.<br><br>During an interview with MDS Nurse # 1 on 12/4/2019 at 2:11 pm, she revealed Resident # 88 was on hospice care a long time before she expired. MDS # 1 stated the MDS dated 8/6/2019 did not have hospice marked and it was incorrect, and she would submit a correction. The MDS Nurse also stated when there was a change in the resident's condition it was reported in the meeting that she attended with the management staff every morning.<br><br>On 12/4/2019 at 4:57 pm, the administrator stated Resident # 88's MDS should have shown that the resident was on hospice care.<br>2) Resident #38 was admitted to the facility on 5/14/19. Her diagnoses included dementia and psychotic disorder. | F 641 | On 12/4/19 the, MDS Coordinator completed a modification to the comprehensive assessment for Resident # 88 to reflect accurate coding of hospice care. Resident # 88 no longer resides in the facility. On 12/20/19 the MDS Coordinator completed modification to the comprehensive assessment for Resident # 38 to reflect accurate coding for the use of antipsychotics.<br><br>On 12/20/19 100% audit was initiated of all current residents most current MDS coding was reviewed for coding accuracy for all residents receiving hospice care and receiving antipsychotic medication to include Resident # 38. This audit was initiated by the Director of Nursing (DON) utilizing the MDS Accuracy QI Tool to ensure that all MDS's assessments to include hospice services and antipsychotic medications have coding accuracy to include all residents that have and/or are currently receiving hospice care or receiving antipsychotic medications within facility. Any identified areas of concerns noted during the audit will be addressed by the MDS nurse to include modifications to the comprehensive assessments with oversite from the Director of Nursing.<br><br>On 12/23/19 an in-service was initiated by the Director of Nursing with the MDS Coordinator and MDS Nurse in regards to accurately coding the MDS, to include proper coding of MDS assessments per the Resident Assessment Instrument | |

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| F 641 | Continued From page 2<br>A review of the most recent Minimum Data Set (MDS) a quarterly review dated 10/10/19 revealed Resident #38 was moderately cognitively impaired. The MDS section N0410 revealed antipsychotic medications were received for 7 days of the look back period. Additional review revealed the section N0450 indicated no antipsychotics were received.<br><br>The care plan updated 9/25/19 stated Resident #38 was care planed for "use of psychotropic drugs having an altering effect on the mind due to depression and paranoia with the potential for dizziness, tremors and insomnia."<br><br>A review of the October 2019 monthly orders listing revealed Risperdal for psychotic disorder was ordered daily for Resident #38.<br><br>On 12/5/19 at 1:20 PM the MDS nurse stated Resident #38 did received antipsychotic medications but she failed to correctly check the box to indicate the antipsychotic medications were received. | F 641 | (RAI) Manual with emphasis that all MDS assessments are completed accurately to reflect residents receiving hospice services and or antipsychotics medications. In-Service was completed on 12/23/2019<br><br>All newly hired MDS Coordinator or MDS nurses will be in-serviced in regards to MDS Accuracy QI Tool during orientation by the Staff Facilitator to include proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately to reflect residents receiving hospice services and or antipsychotics medications. In-Service was completed on 12/4/2019.<br><br>10% audit of completed MDS assessments, to include assessments for resident # 88 utilizing the MDS Accuracy QI Tool will be completed by the DON weekly x 8 weeks, then monthly x 1 month, to ensure accurate coding of the MDS assessment to include residents that receive hospice services. . 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 Administrator will review and initial the MDS Accuracy QI Tool weekly x 8 weeks, then monthly x 1 month, to ensure any areas of concerns have been addressed.<br><br>10% audit of completed MDS | |

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| F 641 | Continued From page 3 | F 641 | assessments, to include assessments for residents receiving hospice services and or antipsychotic medications are acutely coded utilizing the MDS Accuracy QI Tool will be completed by the DON weekly x 8 weeks and monthly x 1 month to ensure accurate coding of the MDS assessment. All identified areas of concern will be addressed immediately by the DON to include additional training and completing necessary modification to the MDS assessment as indicated. The Administrator will review and initial the MDS Accuracy QI Tool weekly x 8 weeks and then monthly x 1 month for accuracy and to ensure any areas of concerns have been addressed.<br>The Administrator will forward the results of MDS Accuracy Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 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. | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician. | F 657 | | 12/23/19 |

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| F 657 | Continued From page 4<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review the facility failed to revise the resident's care plan to accurately reflect the resident's desire for Do not Resuscitate (DNR) order (written instructions from a physician telling health care providers not to perform Cardiopulmonary Resuscitation (CPR) if the resident's heart stops) for 1 of 40 residents (Resident #88) reviewed for care plans.<br><br>Findings included:<br><br>Resident # 88 was admitted to the facility on 3/23/2017 with diagnoses which included diabetes mellitus, dementia with behavior disturbances, and alzheimer's disease. Resident # 88 expired on 10/18/2019 at the facility.<br><br>A physician order dated 7/17/2017 revealed a | F 657 | On 12/3/19 100% audit of all current resident care plans, by the MDS Coordinator for residents with care plans for residents with end of life and desired directives to ensure the care plan reflected residents end of life desired directives regarding Cardiopulmonary Resuscitation or Do Not Resuscitates utilizing a resident census. Any identified areas of concerns will be corrected by the Director of Nursing during the audit. The audit was completed on 12/3/19. Resident # 88 no longer resides in the facility.<br><br>On 12/9/19 an in-service was initiated by the Staff Development Coordinator and the Director of Nursing (DON) for Assistant Director of Nursing (ADON), | |

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| F 657 | Continued From page 5<br>DNR status.<br><br>The care plan dated 3/16/2018 revealed a plan which focused on end of life planning and directives with the goal that Resident # 88's directive would be honored. The intervention showed Resident # 88 as a full code (in the case the heart or/and breathing stops, full code allows all interventions needed to restore breathing or heart functioning.)<br><br>During an interview with minimum data set nurse (MDS) # 1 on 12/4/2019 at 2:11 pm, she revealed it was the Social Worker's responsibility to update the end of life portion of the care plan. MDS #1 also stated the Social Worker was out on Medical Leave. She further stated the care plan should have been updated and it could have been updated by any nurse.<br><br>An interview with the Director of Nursing (DON) and the Administrator on 12/4/2019 at 4:57 pm revealed the Social Worker had been out of work since November 2019 and the facility did not have anyone appointed to cover her responsibilities. The administrator also stated the care plan should have been updated to show the accurate end of life status and placed in Resident # 88's chart. | F 657 | Unit Managers, Social Worker, MDS nurses and hall nurses in regards to developing, implementing and revising a comprehensive care plan for recommendations for end of life and desired directives regarding Cardiopulmonary Resuscitation or Do Not Resuscitates directives. In-service to be completed by 1/2/2020 Any newly hired DON, ADON, Unit Manager, SW, MDS Nurse or hall nurse will be educated by the Staff Facilitator during orientation in regards to developing, implementing and revising a comprehensive care plan for recommendations for end of life and desired directives regarding Cardiopulmonary Resuscitation or Do Not Resuscitates directives.<br><br>10% of residents care plans will be audited using the MDS Care Planning Audit Tool to ensure that developing, implementing and revising a comprehensive care plan for recommendations for end of life and desired directives regarding Cardiopulmonary Resuscitation or Do Not Resuscitates directives are accurate per the resident's desires utilizing the MDS Accuracy audit tool by the Director of Nursing weekly X 8 weeks then monthly X 1 month. Any identified areas of concerns will be corrected by the Director of Nursing during the audit. The DON will review and initial the Care plan audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. | |

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| F 657 | Continued From page 6 | F 657 | The Administrator will forward the results of the Care Plan Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Care Plan Audit 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. | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore | F 690 | | 12/23/19 |

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| F 690 | Continued From page 7<br>continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff, resident, and Physician interviews, the facility failed to prevent a catheter drainage bag from coming in contact with the floor for 2 of 2 residents (Resident #85 and Resident #68) reviewed for catheter care.<br><br>Finding included:<br><br>1. Resident #85 was admitted to the facility on 6/3/2019 with diagnoses which included chronic kidney disease, neuromuscular dysfunction of the bladder, and urine retention.<br><br>A review of the most recent Annual Minimum Data Set (MDS) dated 8/6/2019 revealed Resident #85 cognitive status was unable to be assessed. The resident required extensive assistance with bed mobility and total assistance with all other activities of daily living. The MDS showed Resident #85 had an indwelling catheter.<br><br>The care plan dated 10/10/2017 and revised on 11/21/2019 focused on an altered pattern of urinary elimination with the interventions of catheter care per protocol, change catheter per physician orders, empty drainage bag at the end of each shift, indwelling urinary catheter and observe for signs and symptoms of urinary tract | F 690 | On 12/2/19 resident # 85 and resident # 68 indwelling urinary catheter drainage bag came in contact with the floor.<br>A 100% audit was initiated on 12/2/2019 by the Nursing Supervisor of all residents, to include resident # 85 and resident # 68 with indwelling urinary utilizing a resident census to ensure that the indwelling urinary catheters were not in contact with the floor. Any identified areas of concerns will be corrected during the audit to include securing the indwelling urinary catheters to ensure that the collection bag does not touch the floor. The audit was completed on 12/2/2019.<br><br>On 12/2/2019 100% in-service on Proper placement of catheter drainage bag was initiated by the Administrator and Staff Development Coordinator for all nurse's and certified nurse aides. In addition to catheter drainage bag placement, in-service includes infection control risks and correct tubing placement. The in-service will be completed by 1/2/2020<br>All newly hired clinical staff to include nurses and certified nursing assistants will be educated during orientation in regards | |

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| F 690 | Continued From page 8<br>infection.<br><br>An observation on 12/2/2019 at 10:00 am revealed Resident #85 was resting in bed with his eyes closed and the bed was in a low position. The catheter bag was hanging on the front side of the bed close to where Resident #85's lower leg was on the bed. The bottom part of the drainage bag was observed to be touching the floor.<br><br>An observation on 12/2/2019 at 12:19 pm revealed the resident was still resting in the bed with the bed in a low position. The bottom of the catheter bag was hanging in the same position as previously observed. The drainage bag had urine in it and the bottom of the bag continued to touch the floor.<br><br>An observation on 12/2/2019 at 2:19 pm revealed the resident was in the bed with his eyes closed. The catheter bag had not been repositioned. The bottom of the bag which had drainage in it was on the floor with the top part of the bag leaning forward over the bottom of the bag. The catheter bag was in a loose folded position.<br><br>During an interview with Nurse Aide #5 on 12/2/2019 at 3:43 pm, she stated Resident #85's catheter bag should not be on the floor because of infection issues. NA #5 also stated the resident bed had to be in the lowest position for safety. NA #5 unsuccessfully attempted to reposition the catheter bag to not touch the floor without raising the bed.<br><br>On 12/2/2019 at 3:47 pm during an interview with Nurse #4, she revealed the catheter bag should not be touching the floor because of infection | F 690 | to proper placement of catheter drainage bags to include infection control risk and correct tubing placement<br><br>100% audit of all residents requiring an indwelling urinary catheter to include Resident #85 and Resident #68, will be audited by the Director of Nursing and/or Nurse Administration utilizing Catheter Monitoring Tool weekly x 8 weeks and then monthly x 1 to ensure proper placement of the catheter drainage bags to include not touching the floor. All identified areas of concern will be addressed immediately by the Director of Nursing to include repositioning the indwelling urinary catheter drainage bag to ensure ir not touching the floor. The Director of Nursing will review and initial Catheter Monitoring tool weekly x 8 weeks and monthly x 1 month to ensure completion and that all areas of concerns were addressed<br><br>The DON will forward the results of Catheter Monitoring Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Catheter Monitoring 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 690 | Continued From page 9 | F 690 | | |

concerns. Nurse #4 raised the foot of the bed and NA #5 hung the catheter bag on the side of the bed without the bag touching the floor.

During an interview with the Physician on 12/5/2019 at 10:00 am, she stated the facility had dignity bags to put the catheter bags in that should have been used. The physician also stated the catheter bags should not be touching the floor.

2.Resident #73 was admitted to the facility on 6/4/2019 with diagnoses which included retention of urine, heart failure, and flaccid neuropathic bladder.

A care plan dated 6/6/2019 and revised on 9/20/2019 revealed a plan which focused on altered pattern of urinary elimination with the intervention for catheter care per protocol, change catheter per physician orders, empty drainage bag at the end of each shift, indwelling urinary catheter and observe for signs and symptoms of urinary tract infection.

A review of the most recent quarterly Minimum Data Set (MDS) dated 10/22/2019 revealed Resident #73 was slightly cognitively impaired. The resident required set up assistance for meals and extensive to total assistance for all other activities of daily living.

On 12/2/2019 at 10:47 am, Resident # 73 was observed resting in bed with his eyes open. The indwelling catheter bag was hanging on the front side of the bed with the bottom of the bag touching the floor.

An observation on 12/2/2019 at 2:25 pm Resident

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| F 690 | Continued From page 10<br>#73 was sitting in his room in a wheelchair. The catheter bag was attached to a metal bar under the wheelchair seat. The bottom of the bag was touching the floor.<br><br>During an interview with Nurse Aide #6 on 12/2/2019 at 3:50 pm, she stated the catheter bag should not be on the floor because of infection issues. NA #6 further stated she had been trained on indwelling catheter care.<br><br>On 12/2/2019 at 4:00 pm during an interview, Nurse #5 stated Resident #73's catheter bag should have been attached on the wheelchair to keep the bag from touching the floor.<br><br>During an interview with the Physician on 12/5/2019 at 10:00 am, she stated the facility had dignity bags to put the catheter bags in that should been used. The physician also stated the resident's catheter bag should not be touching the floor especially Resident #73 catheter bag because he was capable of moving his legs. | F 690 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition | F 692 | | 12/23/19 |

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| F 692 | Continued From page 11<br>demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, resident and Physician interviews, the facility failed to provide a nutritional supplement for 1 of 3 residents (Resident #68) reviewed for nutrition.<br><br>Findings included:<br><br>Resident #68 was originally admitted to the facility on 1/3/2019.<br><br>The care plan dated 1/14/2019 revealed a plan which focused on Resident #68 risk for weight changes due to a history of weight changes and dialysis treatment. The goal was the resident will not experience significant weight changes with interventions which included a referral to the dietician for evaluation, a regular no added salt, no concentrated sweet diet with a snack at bedtime and weights per facility protocol.<br><br>Resident #68 was readmitted to the facility on 9/9/2019 with diagnoses which included heart failure, chronic kidney disease, and type 2 diabetes.<br><br>On 10/17/2019, the physician ordered a brand name nutritional supplement twice a day. This product contained 190 calories, 16 grams of | F 692 | On 12/3/2019 Resident # 68 was provided a nutritional supplement per the physician orders by the nursing assistant.<br>.<br>A 100% audit was initiated on 12/3/2019 by the Dietary Manager and Treatment Nurse of all residents, to include Resident # 68 with orders to receive supplements to ensure that all orders were accurately entered into Point Click Care and being administered per physician orders. Any identified areas of concerns will be corrected during the audit to include clarifying the diet orders, ensuring the diet order is documented in the clinical record, providing a diet order form to the dietary department. Audit to be completed by 12/3/2019.<br><br>A 100% in-service was initiated on 12/3/19 by the Staff Development Coordinator for all nurse's, on accuracy of transcription for supplements. In-Service will be completed by 1/2/2020. A 100% in-service was initiated on 12/9/19 by the Staff Development Coordinator for all dietary staff regarding only discontinuing a supplement if there is a physician order to | |

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| F 692 | Continued From page 12<br>protein, 16 grams of carbohydrates, 3 grams of fiber, and 25 vitamins and minerals per 8 ounces serving. There was no stop date with the order.<br><br>A review of the most recent quarterly Minimum Data Set (MDS) dated 11/19/2019 revealed Resident #68 was cognitively intact. The MDS also revealed Resident #68 was on a therapeutic diet and had no weight loss within the last six months. The MDS also showed the resident was on dialysis.<br><br>A review of the latest dietary note dated 11/20/2019 revealed continue the plan of care which included nutritional supplements, a regular no added salt, no concentrated sweet diet with a snack at bedtime, weights, labs, and to monitor Resident #68's oral intake.<br><br>Resident #68's weight for the months of October 2019 through December 2019 were 10/24/19 186 pounds (lbs.), 11/1/2019 187, 11/30/2019 189 and 12/3/2019 189 lbs.<br><br>A review of the Nurse Aide flow sheet for the month of November 2019 revealed no documentation to indicate Resident #68 received a nutritional supplement twice a day.<br><br>During an interview with Resident #68 on 12/3/2019 at 10:00 an, he stated he had an order for low sugar nutritional supplements twice a day and he had received one in a long time. The resident was unable to give a specific time period. Resident #68 also stated that he had mentioned not getting the nutritional supplement to the nurse about 2 weeks ago and still had not received it.<br><br>An interview with Nurse Aide #4 (NA) on | F 692 | do so. In-service will be completed by 1/2/2020. All newly hired staff to include nurses and dietary staff will receive education during orientation by the Staff Development Coordinator to include proper transcription of all supplements in Point Click Care and only discontinuing a supplement if there is a physician's order.<br><br>10% audit of all residents requiring supplements with a physician order to include resident #68 will be audited by the Director of Nursing, Dietary Manager, and/or Nurse Administration utilizing Resident Diet Accuracy QI tool weekly x 8 weeks and monthly x 1 month to ensure that all residents requiring supplements are receiving per physician orders. All areas of concerns will be corrected by the Director of Nursing during the audit. The Director of Nursing (DON) will review and sign the Resident Diet Accuracy QI tool weekly x 8 weeks and monthly x 1 month to ensure completion and that all areas of concerns were addressed to include retraining of clinical staff and completing necessary modification to the resident orders. The Director of Nursing will review and initial the Resident Diet Accuracy QI tool weekly x 8 weeks and monthly x 1 month to ensure all areas of concerns have been addressed.<br><br>The Administrator will forward the results of Resident Diet Accuracy QI tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet | |

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| F 692 | Continued From page 13<br>12/3/2019 at 1:50 pm revealed the nutritional supplements came from the kitchen with the resident's name on the container. The NA stated Resident #68 had not received a nutritional supplement from the kitchen. NA #4 checked the computer and then stated the resident did not have a nutritional supplement on the care guide, so he would not get one.<br><br>During an interview with Nurse #2 on 12/3/2019 at 2:00 pm, she stated the nutritional supplements are given by the nurse aides and documented in the computer.<br><br>An interview with the Dietary Manager (DM) on 12/3/2019 at 2:10 pm revealed she did not think Resident #68 had a current order for a nutritional supplement. The DM checked the computer and could not find the diet order in her computer program. She stated the dietary staff had not been sending Resident #68 a nutritional supplement twice a day.<br><br>On 12/4/2019 3:36 pm during an interview, Nurse # 3 stated Resident #68's diet order was rewritten to make sure the resident did not get any jelly with his bedtime snack. Nurse #3 also stated Resident #68 had mentioned he was not getting the nutritional supplement, but she did not see where the order was still current. Nurse #3 stated she did not put the nutritional supplement on the new diet order.<br><br>An interview with the DON on 12/4/2019 at 3:50 pm revealed the procedures for dietary orders were to enter the order in the computer, complete a dietary form, give the kitchen staff a copy of the form, and the kitchen staff will initial the copy. The DON stated the complete order would not | F 692 | monthly x 3 months and review the Resident Diet Accuracy QI 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 692 | Continued From page 14<br>normally be rewritten to add a dietary preference. The DON further stated Nurse #3 should have gone to the dietary staff to inform the staff of the preference.<br><br>An interview with the Physician on 12/5/2019 at 10:00 am revealed the dietician usually made the recommendations for nutritional supplements. The physician also stated since a recommendation was made, and an order was given, Resident #68 should have received the nutritional supplements as ordered. | F 692 | | |
| F 700 SS=E | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>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.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§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.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced | F 700 | | 12/23/19 |

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| F 700 | Continued From page 15<br>by:<br>Based on observations, record review and resident, family, staff and physician interviews the facility failed to assess two of seven residents for bedrail use. (Residents #74 and #37), and failed to attempt alternatives, review the risks and benefits with the resident or the residents representative, and obtain informed consent prior to the use of bedrails for seven of seven residents reviewed for accident hazards. (Residents #50, #69, #74, #18, #19, #37, #53)<br><br>Findings included:<br><br>1. Resident #50 was admitted to the facility on 11/3/17 with diagnoses including flaccid hemiparesis (paralysis) affecting left non-dominant side.<br>A review of a Minimum Data Set (MDS) assessment dated 10/25/19 indicated Resident #50 was moderately impaired for daily decision making, had adequate hearing and vision without the use of devices, experienced no hallucinations or delusions, and exhibited no behaviors or rejection of care. It further indicated Resident #50 needed extensive assistance of one person for bed mobility and transfers, did not walk, had range of motion (ROM) impairment of the upper and lower extremities on one side, was not able to balance without staff assistance, had no falls, and bedrails were not used as restraints.<br><br>On 12/3/19 at 8:18 AM Resident #50 was observed in bed with the top half bedrails left and right raised. Interview with Resident #50 at that time indicated he liked his bedrails. He stated they helped him to reposition in bed and he did not feel they restrained him in any way. Resident #50 further indicated he did not try to get out of | F 700 | On 12/20/2019 Physical Device Evaluations were initiated for Resident #50, #69, #74, #18, #19, #37, and #53. On 12/20/2019 a 100% audit was initiated by the Director of Nursing of all residents to include resident #50, #69, #74, #18, #19, #37, and #53 utilizing a resident census to ensure the residents have been properly assessed for the use/removal of bed rails and care plans updated. The Evaluations for Resident #50, #69, #74, #18, #19, #37, and #53 were completed on 12/21/2019. Any areas of concern will be addressed during the audit. All actions will be completed by 1/2/2020.<br><br>On 12/20/2019 an in-service on Bed Rails was initiated by the Staff Development Coordinator with the Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS Coordinator, MDS Nurse, Unit Managers and hall nurses in regards to use of bed rails to include: If bed rail use is indicated for a resident the nurse must assess the resident utilizing the Physical Device Evaluation. The bed rails are to be reviewed quarterly if used to include completing the Physical Device Evaluation. Nurse must ensure that the risk and benefits are explained to the resident and/or resident representative if bed rails are used. If bed rails are used resident must be care planned for the use of the bed rails. In-service to be completed by 1/2/2020. All newly hired DON, ADON, Staff Facilitator, MDS Coordinator, MDS Nurse, Unit Managers and hall nurses will be in-serviced by the | |

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| F 700 | Continued From page 16<br>bed by himself, used the call bell if he needed assistance, staff came when he called, and no one in the facility had ever discussed bedrail use with him.<br><br>On 12/4/19 at 8:36 AM Resident #50 was observed in bed with the top half bedrails left and right raised.<br><br>On 12/3/19 at 1:19 PM interview with Nurse #1 indicated she was responsible for Resident #50 and familiar with his care. She stated all the residents she cared for in the facility were using bedrails. She added some residents used bedrails to assist with repositioning but if residents were not able to use the bedrails for repositioning, the bedrails were used to define the bed space and provide a feeling of safety and comfort for the resident. She stated she was not sure who was responsible for assessing residents for bedrail use. She indicated bedrail use was not found on Resident #50's care plan or his care guide.<br><br>On 12/4/19 at 8:38 AM an interview with Nurse Aide #1 indicated she was familiar with Resident #50 and responsible for his care that day. She stated Resident #50 used his side rails to reposition in bed, did not try to get up by himself. She went on to say when residents called for assistance she responded immediately or as soon as she was able to. She indicated she had access to resident care guides, but bedrail use was not on them. She stated most all residents she cared for in the facility had their bedrails raised.<br><br>A review of physician orders for Resident #50 revealed no order for bedrails. | F 700 | Staff Facilitator during orientation in regards to use of bed rails to include: If bed rail use is indicated for a resident the nurse must assess the resident utilizing the Physical Device Evaluation. The bed rails are to be reviewed quarterly if used to include completing the Physical Device Evaluation. Nurse must ensure that the risk and benefits are explained to the resident and/or resident representative if bed rails are used. If bed rails are used resident must be care planned for the use of the bed rails.<br><br>10 % audit of all residents with use and/or removal of bed rails to include resident #50, #69, #74, #18, #19, #37, and #53, using the MDS Accuracy of Assessment – Bedrails QI Tool, will be completed by the Staff Facilitator weekly x 8 weeks, then monthly x 1 month utilizing the Bed Rail Audit Tool to ensure assessment for the use and/or removal of bed rails has been completed. The DON will review the Bed Rail Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure completion and that all areas of concern were addressed.<br><br>The DON will forward the results of the Bed Rail Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Bed Rail Audit 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 700 | Continued From page 17 | F 700 | | |

A review of the most current Bed Rail Assessment form for Resident #50 dated 5/8/18 indicated Resident #50 had not expressed a desire to have his bedrails up, no alternatives to bedrail use were attempted, half bedrails left and right were recommended, and risks, benefits and alternatives to bedrail use had not been explained to Resident #50 or his representative.

On 12/4/19 at 9:10 AM an interview with the MDS nurse indicated she had completed the Bedrail Assessment form dated 5/8/18 for Resident #50. She stated she had not tried alternatives to bedrail use, had not explained the risks or benefits of bedrail use to Resident #50 or his representative, and no consent for bedrail use had been obtained.

On 12/3/19 at 1:43 PM an interview with the Director of Nursing (DON) indicated on 11/27/19 the facility put a performance improvement plan (PIP) in place as bedrail use had been identified as an issue at a corporate meeting. She stated on 11/27/19 the facility identified that all residents having bedrails in use needed to be assessed and have a physical device evaluation. She went on to say the MDS nurse had been completing the Bed Rail Assessments but not on a consistent basis and no other staff member in the facility had been assessing residents for bedrail use. In a follow up interview, the DON stated most all residents in the facility were using bedrails, no alternatives to bedrail use had been tried, no risks or benefits of bedrail use were explained to residents or their representatives, and an informed consent had not been obtained prior to the use of bedrails.

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On 12/4/19 at 9:28 AM an interview with the Administrator indicated the beds used in the facility came with bedrails attached which could be raised or lowered. He went on to say he was not aware of any incidents in the facility involving bedrails. He stated to his knowledge no alternatives to bedrail use in the facility were tried, risks and benefits of bedrail use were not discussed with residents or their representatives, and no informed consent for bedrail use had been obtained prior to use of bedrails.

On 12/5/19 at 9:29 AM interview with the Physician indicated the facility usually made her aware if residents or family members insisted on using bedrails. She stated if staff called her regarding the use of bedrails she instructed staff on the need to educate residents and families about the risks and benefits of bedrail use.

2.Resident #69 was admitted to the facility on 12/31/16 with diagnoses including Alzheimer's disease.

A review of an MDS assessment dated 10/8/19 indicted Resident #69 was severely impaired for daily decision making, had adequate hearing and vision without the use of devices, required the total assistance of one person for bed mobility and transfers, did not walk, had no ROM impairment, had no hallucinations or delusions, and behavioral symptoms including yelling not directed at others were noted one to three days of the seven-day assessment period. It further indicated Resident #69 had no falls and bedrails were not used as a restraint.

On 12/2/19 at 12:05 PM Resident #69 was observed in bed with her top half bedrails left and

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right raised. She appeared to be watching the television.

On 12/3/19 at 1:07 PM Resident #69 was observed in bed awake. Resident #69 was speaking to someone, but no one was observed in the room. Her top half bedrails left, and right were raised.

On 12/3/19 at 1:19 PM an interview with Nurse #1 indicated she was responsible for Resident #69 and familiar with her care. She stated all the residents she cared for in the facility were using bedrails. She added some residents used bedrails to assist with repositioning, but if residents were not able to use the bedrails for repositioning then the bedrails were used to define the bed space and provide a feeling of safety and comfort for the resident. She stated she was not sure who was responsible for assessing residents for bedrail use. She indicated bedrail use was not found on Resident #69's care plan or her care guide.

On 12/4/19 at 8:38 AM an interview with Nurse Aide #3 indicated she was familiar with Resident #69 and was responsible for her care. She stated Resident #69 was not able to use her bedrails to reposition in bed as she was totally dependent on staff for her care. She went on to say Resident #69 did not try to get up by herself. Nurse Aide #3 further indicated the bedrails helped Resident #69 define the space of her bed and feel safe. She indicated Resident #69 did not use her call bell, but she checked on her frequently at least every two hours to see if she needed anything. She went on to say she did not know how staff knew which residents used bedrails and which did not because it wasn't in the care guide. She further

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| F 700 | Continued From page 20 | F 700 | | |

indicated all resident's bedrails were usually just raised.

A review of physician orders for Resident #69 revealed no order for bedrails.

A review of the most current Bed Rail Assessment form for Resident #69 dated 7/10/18 indicated Resident #69 had not expressed a desire to have her bedrails up, no alternatives to bedrail use had been attempted, half bedrails left and right were recommended, and risks, benefits, and alternatives to bedrail use had not been explained to the Resident #69 or her representative.

On 12/4/19 at 9:10 AM an interview with the MDS nurse indicated she completed the bedrail assessment dated 7/10/18 for Resident #69. She stated she had not tried alternatives to bedrail use, had not explained the risks or benefits of bedrail use to Resident #69 or her representative, and no consent for bedrail use had been obtained.

On 12/3/19 at 1:43 PM interview with the Director of Nursing (DON) indicated on 11/27/19 the facility put a performance improvement plan (PIP) in place as bedrail use had been identified as an issue at a corporate meeting. She stated on 11/27/19 the facility identified that all residents having bedrails in use needed to be assessed and have a physical device evaluation. She went on to say the MDS nurse had been completing Bed Rail Assessments but not on a consistent basis and no other staff member in the facility had been assessing residents for bedrail use. In a follow up interview, the DON stated most all residents in the facility were using bedrails, no

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alternatives to bedrail use had been tried, no risks or benefits of bedrail use were explained to residents or their representatives, and an informed consent had not been obtained prior to the use of bedrails.

On 12/4/19 at 9:28 AM an interview with the Administrator indicated the beds used in the facility came with bedrails attached which could be raised or lowered. He went on to say he was not aware of any incidents in the facility regarding bedrails. He stated to his knowledge no alternatives to bedrail use in the facility were tried, risks and benefits of bedrail use were not discussed with residents or their representatives, and no informed consent for bedrail use had been obtained prior to use of bedrails.

On 12/5/19 at 9:29 AM interview with the Physician indicated the facility usually made her aware if residents or family members insisted on using bedrails. She stated if staff called her regarding the use of bedrails she instructed staff on the need to educate residents and families about the risks and benefits of bedrail use.

3. Resident #74 was admitted to the facility 6/17/19 with diagnoses including end stage renal disease.
A review of an MDS assessment dated 10/24/19 indicated Resident #74 was independent for daily decision making. It further indicated Resident #74 had adequate hearing and vision, used glasses, had no hallucinations, delusions or rejection of care, exhibited no behaviors, required the extensive assistance of one person for bed mobility, supervision of one person for transfers, was not steady but able to stabilize with the assistance of one person, had no limitations of

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ROM, used a walker, had no falls, and bedrails were not used as restraints.

On 12/2/19 at 2:44 PM Resident #74 was observed in bed with her top half bedrails left and right raised.

On 12/3/19 at 1:05 PM Resident #74 was observed in her bed with top half bedrails left and right raised. Interview with Resident #74 at that time indicated she used her bedrails to assist her with transfers and also with repositioning in bed. She stated she did not try to get up by herself but used her call bell for assistance and staff came to help her. She indicated she did not feel the bedrails interfered with her mobility in any way or served as a restraint. She indicated no staff in the facility had ever spoken to her about her bedrails, they had just always been up.

On 12/3/19 at 1:19 PM interview with Nurse #1 indicated she was responsible for Resident #74 that day and familiar with her care. She stated all the residents she cared for in the facility were using bedrails. She added some residents used bedrails to assist with repositioning but if residents were not able to use the bedrails for positioning, the bedrails were used to define the bed space and provide a feeling of safety and comfort for the resident. She stated she was not sure who was responsible for assessing residents for bedrail use. She indicated bedrail use was not found on Resident #74's care plan or her care guide.

On 12/4/19 at 8:38 AM interview with Nurse Aide #3 indicated she was familiar with Resident #74 and responsible for her care that day. She stated Resident #74 used her side rails to reposition

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herself in bed. Nurse Aide #3 added the use of bedrails was not found on Resident #74's care guide, Resident #74 just usually had them up.

A review of physician orders for Resident #74 revealed no order for bedrails.

No bedrail assessment was found in Resident #74's medical record.

On 12/4/19 at 9:10 AM interview with the MDS nurse indicated she had not assessed Resident #74 for the use of bedrails. She stated she had not tried alternatives to bedrail use, had not explained the risks or benefits of bedrail use to Resident #74 or her representative, and no consent for bedrail use had been obtained. She went on to say about a year ago the company had taken away the Bed Rail Assessment form and no alternative was given so she stopped doing bedrail assessments.

On 12/3/19 at 1:43 PM interview with the Director of Nursing (DON) indicated on 11/27/19 the facility put a performance improvement plan (PIP) in place as bedrail use had been identified as an issue at a corporate meeting. She stated on 11/27/19 the facility identified that all residents having bedrails in use needed to be assessed and have a physical device evaluation. She went on to say the MDS nurse had been doing bed rail assessments but not on a consistent basis and no other staff member in the facility had been assessing residents for bedrail use. The DON further indicated Resident #74 had been admitted after the facility stopped using the Bedrail Assessment form and no bedrail assessment for Resident #74 had been completed. In a follow up interview, the DON stated most all residents in

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the facility were using bedrails, no alternatives to bedrail use had been tried, no risks or benefits of bedrail use were explained to residents or their representatives, and an informed consent had not been obtained prior to the use of bedrails.

On 12/4/19 at 9:28 AM interview with the Administrator indicated the beds used in the facility came with bedrails attached which could be raised or lowered. He went on to say he was not aware of any incidents in the facility regarding bedrails. He stated to his knowledge no alternatives to bedrail use in the facility were tried, risks and benefits of bedrail use were not discussed with residents or their representatives, and no informed consent for bedrail use had been obtained prior to use of bedrails.

On 12/5/19 at 9:29 AM interview with the Physician indicated the facility usually made her aware if residents or family members insisted on using bedrails. She stated if staff called her regarding the use of bedrails she instructed staff on the need to educate residents and families about the risks and benefits of bedrail use.

4.Resident #18 was admitted to the facility on 8/23/17 with diagnoses including generalized muscle weakness and dementia.

A review of an MDS assessment for Resident #18 dated 9/19/19 indicated Resident #18 was severely impaired for daily decision making. It further indicated her vision and hearing were adequate without the use of devices, she exhibited no delusions or hallucinations, had no behaviors or rejection of care, required the extensive assistance of one person for bed mobility, the total assistance of one person for

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transfers, did not walk, was not steady during transfers and needed assistance with balance, had no functional impairment of ROM, had no falls, and bedrails were not used as restraints.

On 12/2/19 at 2:14 PM Resident #18 was observed in bed with top half bedrails left and right raised.. She was resting with her eyes closed.

On 12/3/19 at 8:11 AM Resident #18 was observed in bed eating breakfast with top half bedrails left and right raised.

On 12/3/19 at 1:19 PM an interview with Nurse #1 indicated she was responsible for Resident #18 that day and familiar with her care. She indicated Resident #18 did not try to get up by herself. She stated all the residents she cared for in the facility were using bedrails. She added some residents used bedrails to assist with repositioning but if residents were not able to use the bedrails for positioning, the bedrails were used to define the bed space and provide a feeling of safety and comfort for the resident. She stated she was not sure who was responsible for assessing residents for bedrail use. She indicated bedrail use was not found on Resident #18's care plan or her care guide.

On 12/4/19 at 8:38 AM interview with Nurse Aide #2 indicated she was not assigned to Resident #18 that day, but was familiar with Resident #18 and had provided care to her in the past. She stated at times Resident #18 tried to get out of bed by herself and the bedrails helped keep Resident #18 from falling. She indicated she had access to resident care guides, but bedrail use was not on them. She stated most all residents

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she cared for in the facility had their bedrails raised.

A review of physician orders for Resident #18 revealed no order for bedrails.

A review of the most current Bed Rail Assessment form for Resident #18 dated 7/3/18 indicated Resident #18 had not expressed a desire to have her bedrails up, no alternatives to bedrail use were attempted, half bedrails left and right were recommended, and risks, benefits and alternatives to bedrail use had not been explained to Resident #18 or her representative.

On 12/4/19 at 9:10 AM interview with the MDS nurse indicated she completed the Bed Rail Assessment form dated 7/3/18 for resident #18. She stated she had not tried alternatives to bedrail use, had not explained the risks or benefits of bedrail use to Resident #18 or her representative, and no consent for bedrail use had been obtained.

On 12/3/19 at 1:43 PM interview with the Director of Nursing (DON) indicated on 11/27/19 the facility put a performance improvement plan (PIP) in place as bedrail use had been identified as an issue at a corporate meeting. She stated on 11/27/19 the facility identified that all residents having bedrails in use needed to be assessed and have a physical device evaluation. She went on to say the MDS nurse had been doing bed rail assessments but not on a consistent basis and no other staff member in the facility had been assessing residents for bedrail use. In a follow up interview, the DON stated most all residents in the facility were using bedrails, no alternatives to bedrail use had been tried, no risks or benefits of

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bedrail use were explained to residents or their representatives, and an informed consent had not been obtained prior to the use of bedrails.

On 12/4/19 at 9:28 AM interview with the Administrator indicated the beds used in the facility came with bedrails attached which could be raised or lowered. He went on to say he was not aware of any incidents in the facility regarding bedrails. He stated to his knowledge no alternatives to bedrail use in the facility were tried, risks and benefits of bedrail use were not discussed with residents or their representatives, and no informed consent for bedrail use had been obtained prior to use of bedrails.

On 12/5/19 at 9:29 AM interview with the Physician indicated the facility usually made her aware if residents or family members insisted on using bedrails. She stated if staff called her regarding the use of bedrails she instructed staff on the need to educate residents and families about the risks and benefits of bedrail use.

5.Resident #19 was admitted to the facility on 5/14/97 with diagnoses including acute respiratory failure with hypoxia (low blood oxygen level).

A review of Resident #19's most current MDS assessment dated 9/20/19 indicated she was severely impaired for daily decision making, rarely if ever understood, sometimes understands, had no speech, experienced no hallucinations or delusions, and her vision and hearing were adequate without devices. It further indicated Resident #19 required the total assistance of one person for bed mobility and transfers, had impaired ROM of both upper and lower

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extremities on one side, had no falls, used no mobility devices, and bedrails were not used as restraints.

On 12/2/19 at 12:00 PM Resident #19 was observed awake in bed with the top half bedrails left, and right raised.

On 12/3/19 at 8:12 AM Resident #19 was observed awake in bed with the top half bedrails left, and right raised.

On 12/3/19 at 1:19 PM interview with Nurse #1 indicated she was responsible for Resident #19 that day and familiar with her care. She indicated Resident #19 did not try to get up by herself. She stated all the residents she cared for in the facility were using bedrails. She added some residents used bedrails to assist with repositioning, but if residents were not able to use the bedrails for positioning, the bedrails were used to define the bed space and provide a feeling of safety and comfort for the resident. She stated she was not sure who was responsible for assessing residents for bedrail use. She indicated bedrail use was not found on Resident #19's care plan or her care guide.

On 12/4/19 at 8:38 AM interview with Nurse Aide #2 indicated she was familiar with Resident #19 and had provided care to her in the past. She stated Resident #19 could not use her bedrails to assist with repositioning in bed and required the total assistance of staff for that. She went on to say she thought Resident 19's bedrails were for safety. Nurse Aide #2 further indicated when staff assisted Resident #19 to turn in bed the bed rails kept Resident #19 from rolling off the bed. She indicated she had access to resident care guides,

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but bedrail use was not on them. She stated most all residents she cared for in the facility for had their bedrails raised.

A review of physician orders for Resident #19 revealed no order for bedrails.

A review of the most current Bed Rail Assessment form for Resident #19 dated 5/21/18 indicated Resident #19 had not expressed a desire to have her bedrails up, no alternatives to bedrail use were attempted, half bedrails left and right were recommended, and risks, benefits and alternatives to bedrail use had not been explained to Resident #19 or her representative.

On 12/4/19 at 9:10 AM interview with the MDS nurse indicated she completed the Bed Rail Assessment form dated 7/3/18 for Resident #19. She stated she had not tried alternatives to bedrail use, had not explained the risks or benefits of bedrail use to Resident #19 or her representative, and no consent for bedrail use had been obtained.

On 12/3/19 at 1:43 PM interview with the Director of Nursing (DON) indicated on 11/27/19 the facility put a performance improvement plan (PIP) in place as bedrail use had been identified as an issue at a corporate meeting. She stated on 11/27/19 the facility identified that all residents having bedrails in use needed to be assessed and have a physical device evaluation. She went on to say the MDS nurse had been doing bed rail assessments, but not on a consistent basis and no other staff member in the facility had been assessing residents for bedrail use. In a follow up interview, the DON stated most all residents in the facility were using bedrails, no alternatives to

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bedrail use had been tried, no risks or benefits of bedrail use were explained to residents or their representatives, and an informed consent had not been obtained prior to the use of bedrails.

On 12/4/19 at 9:28 AM interview with the Administrator indicated the beds used in the facility came with bedrails attached which could be raised or lowered. He went on to say he was not aware of any incidents in the facility regarding bedrails. He stated to his knowledge no alternatives to bedrail use in the facility were tried, risks and benefits of bedrail use were not discussed with residents or their representatives, and no informed consent for bedrail use had been obtained prior to use of bedrails.

On 12/5/19 at 9:29 AM interview with the Physician indicated the facility usually made her aware if residents or family members insisted on using bedrails. She stated if staff called her regarding the use of bedrails she instructed staff on the need to educate residents and families about the risks and benefits of bedrail use.

6.Resident #37 was admitted to the facility on 7/26/19 with diagnoses including non-traumatic intracerebral (brain) hemorrhage (bleeding).

A review of Resident #37's most recent MDS assessment dated 10/10/19 indicated Resident #37 was severely impaired for daily decision making, rarely if ever understood, sometimes understands, had adequate hearing with no device, experienced no hallucinations or delusions and had no behaviors or rejection of care. It further indicated Resident #37 needed extensive assistance of two people for bed mobility and transfers, did not walk, was only able

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to balance with staff assistance during transfers, had no falls, had ROM impairment upper and lower extremities on both sides, and bedrails were not used as restraints.

On 12/2/19 at 2:05 PM Resident was observed asleep in bed with top half bedrails left and right raised.

On 12/3/19 at 8:22 AM Resident #37 was observed in bed awake with top half bedrails left and right raised.

On 12/3/19 at 1:19 PM interview with Nurse #1 indicated she was responsible for Resident #37 that day and familiar with his care. She indicated Resident #37 did not try to get up by himself. She stated all the residents she cared for in the facility were using bedrails. She added some residents used bedrails to assist with repositioning, but if residents were not able to use the bedrails for positioning, the bedrails were used to define the bed space and provide a feeling of safety and comfort for the resident. She stated she was not sure who was responsible for assessing residents for bedrail use. She indicated bedrail use was not found on Resident #19's care plan or her care guide.

On 12/4/19 at 8:38 AM interview with Nurse Aide #2 indicated she was familiar with Resident #37 and had provided care to him in the past. She stated Resident #37 could use his bedrails to assist with repositioning in bed. She went on to say she thought Resident #37's bedrails were also used for safety because he could move around in the bed and they prevented him from falling out. Nurse Aide #2 further indicated Resident #37 did not try to get up by himself. She

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indicated she had access to resident care guides, but bedrail use was not on them. She stated most all residents she cared for in the facility for had their bedrails raised.

A review of physician orders for Resident #37 revealed no order for bedrails.

On 12/4/19 at 9:10 AM interview with the MDS nurse indicated she had not assessed Resident #37 for the use of bedrails. She stated she had not tried alternatives to bedrail use, had not explained the risks or benefits of bedrail use to Resident #37 or his representative, and no consent for bedrail use had been obtained. She went on to say about a year ago the company had taken away the Bed Rail Assessment form and no alternative was given so she stopped doing bedrail assessments.

On 12/3/19 at 1:43 PM interview with the Director of Nursing (DON) indicated on 11/27/19 the facility put a performance improvement plan (PIP) in place as bedrail use had been identified as an issue at a corporate meeting. She stated on 11/27/19 the facility identified that all residents having bedrails in use needed to be assessed and have a physical device evaluation. She went on to say the MDS nurse had been doing bed rail assessments, but not on a consistent basis and no other staff member in the facility had been assessing residents for bedrail use. The DON further indicated Resident #37 had been admitted after the facility stopped using the Bedrail Assessment form and no bedrail assessment for Resident #37 had been completed. In a follow up interview, the DON stated most all residents in the facility were using bedrails, no alternatives to bedrail use had been tried, no risks or benefits of

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bedrail use were explained to residents or their representatives, and an informed consent had not been obtained prior to the use of bedrails.

On 12/4/19 at 9:28 AM interview with the Administrator indicated the beds used in the facility came with bedrails attached which could be raised or lowered. He went on to say he was not aware of any incidents in the facility regarding bedrails. He stated to his knowledge no alternatives to bedrail use in the facility were tried, risks and benefits of bedrail use were not discussed with residents or their representatives and no informed consent for bedrail use had been obtained prior to use of bedrails.

On 12/4/19 at 11:58 AM a telephone interview with Resident #37's Representative indicated no one from the facility had ever spoken to her regarding the risks and benefits of bedrail use, alternatives to bedrail use, or obtained her consent for bedrail use for Resident #37.

On 12/5/19 at 9:29 AM interview with the Physician indicated the facility usually made her aware if residents or family members insisted on using bedrails. She stated if staff called her regarding the use of bedrails she instructed staff on the need to educate residents and families about the risks and benefits of bedrail use.

7.Resident #53 was admitted to the facility on 12/11/15 with diagnoses including Parkinson's disease.
A review of the most current MDS for Resident #53 dated 10/29/19 indicated she was moderately impaired for daily decision making, had adequate vision and hearing without a device, experienced no hallucinations, delusions and did not reject

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care. It further indicated Resident #53 required the extensive assistance of two people for bed mobility, the extensive assistance of one person for transfers which occurred only once or twice during the assessment period, had mobility impairment of the upper and lower extremities on both sides, had no falls, and bedrails were not used as restraints.

On 12/2/19 at 3:06 PM Resident #53 was observed in bed asleep with top half bedrails left and right raised.

On 12/3/19 at 1:12 PM Resident #53 was observed in bed awake with top half bedrails left and right raised. Interview with Resident #53 at that time indicated she liked her bedrails. She stated she used them to assist staff with turning and repositioning in bed. She stated she did not recall anyone in the facility ever asking her about bedrails, but she did not feel they restrained her or interfered with her mobility in any way. Resident #53 further indicated she did not try to get out of bed without staff assistance.

On 12/3/19 at 1:19 PM interview with Nurse #1 indicated she was responsible for Resident #53 that day and familiar with her care. She indicated Resident #53 did not try to get up by herself. She stated all the residents she cared for in the facility were using bedrails. She added some residents used bedrails to assist with repositioning, but if residents were not able to use the bedrails for positioning, the bedrails were used to define the bed space and provide a feeling of safety and comfort for the resident. She stated she was not sure who was responsible for assessing residents for bedrail use. She indicated bedrail use was not found on Resident #53's care plan or her care

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guide.

On 12/4/19 at 8:20 AM interview with Nurse Aide #3 indicated she was familiar with Resident #53 and had provided care to her in the past. She stated Resident #53 used her bedrails to assist staff when repositioning in bed. Nurse Aide #3 indicated Resident #53 did not try to get up unassisted. Nurse Aide #3 indicated she had access to resident care guides, but bedrail use was not on them. She stated most all residents she cared in the facility for had their bedrails raised.

A review of physician orders for Resident #53 revealed no order for bedrails.

A review of the most current Bed Rail Assessment form for Resident #53 dated 5/1/18 indicated Resident #53 had not expressed a desire to have her bedrails up, no alternatives to bedrail use were attempted, half bedrails left and right were recommended, and risks, benefits and alternatives to bedrail use had not been explained to Resident #53 or her representative.

On 12/4/19 at 9:10 AM interview with the MDS nurse indicated she completed the Bed Rail Assessment form dated 5/1/18 for Resident #53. She stated she had not tried alternatives to bedrail use, had not explained the risks or benefits of bedrail use to Resident #53 or her representative, and no consent for bedrail use had been obtained.

On 12/3/19 at 1:43 PM interview with the Director of Nursing (DON) indicated on 11/27/19 the facility put a performance improvement plan (PIP) in place as bedrail use had been identified as an

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| F 700 | Continued From page 36<br>issue at a corporate meeting. She stated on 11/27/19 the facility identified that all residents having bedrails in use needed to be assessed and have a physical device evaluation. She went on to say the MDS nurse had been doing bed rail assessments, but not on a consistent basis and no other staff member in the facility had been assessing residents for bedrail use. In a follow up interview, the DON stated most all residents in the facility were using bedrails, no alternatives to bedrail use had been tried, no risks or benefits of bedrail use were explained to residents or their representatives, and an informed consent had not been obtained prior to the use of bedrails.<br><br>On 12/4/19 at 9:28 AM interview with the Administrator indicated the beds used in the facility came with bedrails attached which could be raised or lowered. He went on to say he was not aware of any incidents in the facility regarding bedrails. He stated to his knowledge no alternatives to bedrail use in the facility were tried, risks and benefits of bedrail use were not discussed with residents or their representatives, and no informed consent for bedrail use had been obtained prior to use of bedrails.<br><br>On 12/5/19 at 9:29 AM interview with the Physician indicated the facility usually made her aware if residents or family members insisted on using bedrails. She stated if staff called her regarding the use of bedrails she instructed staff on the need to educate residents and families about the risks and benefits of bedrail use. | F 700 | | |
| F 809 SS=E | Frequency of Meals/Snacks at Bedtime<br>CFR(s): 483.60(f)(1)-(3)<br><br>§483.60(f) Frequency of Meals | F 809 | | 12/23/19 |

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| F 809 | Continued From page 37<br>§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.<br><br>§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.<br><br>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident council meeting interviews, staff interviews and record review the facility failed to offer a nourishing bedtime snack to residents when the time between the evening meal and the following morning meal was greater than 14 hours.<br><br>The findings included:<br><br>During the resident council meeting on 12/3/19 at 2:04 PM the residents said those residents with diabetes received a bedtime snack with their name on it but the other residents were not offered a bedtime snack.<br><br>A review of the "Line Cart Times" revealed the dinner cart time was 4:50 PM and the breakfast cart time was 7:15 AM. | F 809 | On 12/4/2019 the facility, initiated supplying a nourishing protein-based bedtime snacks for each resident consistent with the resident's plan of care.<br><br>100% in-service was initiated on 12/4/2019 by the Administrator and Staff Development Coordinator with all RN's, LPN's, and Certified Nurse Aides on the availability of different bedtime snacks, including protein-based option(s), where they will be located, and that all residents must be offered a bedtime snack. Additionally, all clinical staff answered a Staff Questionnaire on 12/18/19. The questions read as follows: 1. Who do you provide a HS Snack to? 2. Where are the HS Snacks located? Following the | |

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| F 809 | Continued From page 38<br><br>During an interview with Nursing Assistant (NA) #2 on 12/4/19 at 4:57 PM she stated some residents get specific snacks at bedtime. The example she provided was residents with diabetes who had assigned snacks and some other residents received snacks with their name on them. NA #2 then stated if other residents requested a snack she would provide them with a snack which she obtained from the nourishment room. She stated the snack was usually crackers or cookies and juice if the resident wanted juice.<br><br>Observations of the nourishment rooms with the Director of Nursing on 12/5/19 at 12:09 PM revealed the refrigerators contained ice cream, milk and juice. No non-refrigerated items were observed in the nourishment room.<br><br>During an interview with the dietary manager on 12/5/19 at 12:20 PM she reviewed the "Line Cart Times" and reported there was more than 14 hours between dinner and breakfast. She then stated the daily snack delivered to the nourishment room was graham crackers, sugar free cookies and ice cream. She added protein rich snacks were not regularly stocked in the nourishment room.<br><br>During the interview with the dietary manager on 12/5/19 at 12:20 PM the assistant dietary manager was also present. The assistant dietary manager stated she was aware if the time between dinner and breakfast exceeded 14 hours it also needed approval of the resident council. She said they did not have resident council approval. | F 809 | questions, available space was provided to explain if re-training was needed and provided by the Staff Development Coordinator. The questionnaire includes staff, auditor (Staff Development Coordinator) and Administrator signatures. A 100% in-service was initiated on 12/11/19 by the Staff Development Coordinator with all dietary staff on preparing a nourishing protein-based bedtime snack such as a ham, turkey or peanut butter sandwich or other protein- based snack as requested. The in-services and staff questionnaires will be completed by 1/2/2020. Any newly hired Nurses, Certified Nursing Assistants, and Dietary Staff will be educated during orientation by Staff Development Coordinator on location of HS snacks, different types of HS snacks, who receives HS snacks, preparing a nourishing protein-based bedtime snack and any other relevant information regarding resident HS snacks.<br><br>10% of all residents requiring a nourishing protein based snack will be audited by the by the Administrator utilizing the HS Protein Based Snack Audit Tool weekly x 8 weeks and monthly x 1 month to ensure that all residents have access to a nourishing protein- based bedtime snack. All areas of concerns will be corrected by the Administrator during the audit. The Administrator will review and sign the HS Protein Based Snack Audit Tool weekly x 8 weeks and monthly x 1 month to ensure completion and that all areas of concerns were addressed. | |

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| F 809 | Continued From page 39 | F 809 | The Administrator will forward the results of HS Protein Based Snack Audit Tool HS Protein Based Snack Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the HS Protein Based Snack Audit 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. | |