Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968408	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPORT SENIOR LIVING, LLC	8341 LAKE CROWELL CIR ORLANDO, FL 32836

(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) COMPLETE DATE
A 000	Initial Comments Complaint Investigation #2023000699 was conducted on [redacted]. Bridgeport Senior Living had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C.	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for and injuries for 2 of 7 sampled residents (#4 & #5), and failed to have documentation to indicate proactive measures were implemented to prevent the development and worsening of , for 1 of 7 sampled residents (#4). Findings: 1. Resident #4's record revealed a facility admission date of . An 1823 health assessment form indicated the resident's	A 025		

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A 025	Continued From page 2 diagnoses were and . She was non-ambulatory, and alert, a risk, on hospice care and required assistance with all Activities of Daily Living (ADLs) and transferring. The form indicated "no" as to whether the resident had any , 3, or 4 On , a health care provider ordered a gel cushion. On , a health care provider ordered half bed side rails to enable bed mobility. On , the resident was admitted to hospice services. There was no facility documentation in the resident's record to indicate the development of A hospice plan of care (POC) indicated " to left , -dressed with medihoney and Mepilex. Patient continues progressive decline. Patient observed during visit on sitting in wheelchair, unable to keep and in straight position requiring pillow for support. Patient opens occasionally in response to voice but unable to follow commands. Per facility, patient now eating about 25% of meals with assistance. Upper extremities rigid with right ." A hospice POC indicated " to left , new dressed with medihoney and optifoam, redness to right . Patient opens occasionally in response to voice but unable to follow commands. No meaningful interaction with occasional incoherent, babbling speech. Patient	A 025		

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A 025	Continued From page 3 sleeps about 18-20 hours per day. Per facility, patient eating about 50-75% of meals with assistance. Upper extremities rigid with right . " A and a hospice nurse's note indicated left , and had blanchable , (redness). A hospice POC indicated " , to left , and , ". A hospice nurse's note indicated left , and had blanchable right , had non-blanchable , (non-blanchable - discoloration of the skin that does not turn white when pressed. pubmed.ncbi.nlm.nih.gov) A hospice nurse's note indicated left , had brown eschar and , had blanchable , right , measured 3 centimeters (cm) and had blanchable , . "There are two main types of tissue present in : eschar and . Eschar presents as dry, thick, leathery tissue that is often tan, brown or black. is characterized as being yellow, tan, green or brown in color and may be moist, loose, and stringy in appearance." (Retrieved from .com on). A hospice POC indicated " , to left , and , . Left , worse". A hospice nurse's note indicated left , measured 2.5 cm by 3 cm. measured 2 cm by 0.5 cm. Right	A 025		

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A 025	Continued From page 4 had blanchable .	A 025		
	A hospice nurse's note indicated left , was with eschar and . was right , had non-blanchable ," covered with or eschar are by definition ." (Retrieved from .com on).			
	A health care provider's note indicated "pressure injury causes: bed bound, and wheelchair bound status, exposure to , hospice nursing stated that she has noticed patient sitting on her wheelchair for a long time and soaked diapers. Left : full-thickness pressure injury. Length/width: 2.5 cm x 3.0 cm. Depth: 0.3 cm. : length/width: 2.0 cm x 1.5 cm. Depth: 0.2 cm. Patient's pressure injury is attributed not only to pressure but includes the factors, which in this case is immobility, nutrition, hydration, medications and . All these factors influence tissue , and that ultimately affects skin stability. Systemic factors affecting healing: , , immobility, , and . Tissue tolerance to pressure, shear and friction has decreased due to poor circulation, decreased and long-term bed bound status."			
	A hospice POC recommendations indicated "reposition every 2 hours while patient is in bed with wedge pillow. , to left , right , and ."			
	A facility note indicated 7:35 AM, "Admin (administrator) called hospice to assess resident."			

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A 025	Continued From page 5	A 025		

7:45 am "admin received call from caregiver stating resident had . Caregiver stated she was doing care, had resident on the edge of the bed, turned around to grab something and resident rolled off the bed. Resident received to forehead. is stabilized. No other injury apparent". At 7:50 AM, "Admin called POA (power of attorney) to report. POA did not answer. Admin texted POA". At 8:05 Am, "POA returned call and updated on . POA agreed upon plan of care". At 10:30 Am, "Admin arrived at facility. Hospice nurse was evaluating resident and writing report. Nurse stated there were two , one on resident's left and one under residents left cage. Admin answered a few questions for nurse and nurse left a list of signs to watch for a concussion on resident. Nurse left". At 11 AM, "Admin was inspecting on resident and noticed it was still and unbandaged. Admin called hospice to have another nurse out to see resident. NP (nurse practitioner) aware". At 3 PM, APRN (advanced practice registered nurse) suggested med change. Med change- , 5/325mg 8a/8p twice daily , 1000mg Noon."

A hospice nurse's note read, "Patient has an egg size bump on her left forehead with in a triangular shape. It is not at present. Left is light pink with mild over a 3 x 4 cm area. Left mid outer with mild . Left a dark 2 x 3 cm, unsure if that is from . Patient touched on both side of body. She is nonverbal but does has no negative moans or sounds and no grimacing. Patient did not have loss of and pupils remains equal and reactive."

A health care provider's note read, "Left

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A 025	Continued From page 6 : Full thickness pressure injury. Length/width: 2.0 cm x 3.0 cm. Depth: 1.0 cm. Undermining 3.0 cm at 6 -9 o clock. . . : Length/width: 2.0 cm x 3.0 cm. Depth: 0.2 cm. . . Right : . No open pressure injury surrounding DTI (,). Measures 1.0 x 3.0 cm with 6.0 x 7.0 cm . . . Patient had a today and her left is noted with a with dried on it and some dried on her . Appears as a with no deep injury." , (DTI) , are defined as "purple or maroon localized area of discolored intact skin or -filled due to damage of underlying soft tissue from pressure and/or shear." (www.ncbi.nlm.nih.gov/pmc/articles/PMC7950046/) A health care provider's note indicated "Left : Full thickness pressure injury. Length/width: 1.5 cm x 3.0 cm. Depth: 2.0 cm. Undermining 3.0 cms at 6 -9 o clock. . . : Length/width: 2.5 cm x 2.0 cm. Depth: 0.2 cm . . . Right : . No open pressure injury surrounding DTI. Measures 1.5x 1.5 cm with 7.0 x 10.0 cm." On at 10:10 AM, resident #4 was seen positioned on her left side in her bed. On at 1:30 PM, the administrative assistant said that caregiver B, the caregiver who provided care to the resident when she off the bed on , "called me around the time it happened to report it. We called staff F, the administrator of other commonly owned assisted	A 025		

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A 025	Continued From page 7 living facilities, and we had hospice come in and evaluate her. We spoke with the daughter together. Hospice came out pretty much right away." Caregiver B's last day of employment was on . On at 11:58 AM, staff F said the facility's administrator was not available, even by phone, and that her phone number was forwarded to staff F's phone. On at 12:50 PM, resident #4 was seen positioned on her left side in her bed. Caregiver A said she had recently provided the resident with care then positioned her on her left side. When asked why she did not position the resident on either her right side or , the caregiver said because "the on the resident's right side is larger than the one on her left , and the resident appears to be in , when on her right side". The caregiver then made a grunting type noise when describing the resident's response when placed on her right side. On at 2:50 PM, the resident was seen positioned on her right side. On at 3:15 PM with assistance from hospice nurse G, the resident's were observed. Both resident's were at the . The measured approximately 3 cm by 6 cm by 1cm. The bed was covered 100% with yellow . The left , measured approximately 2 cm by 2 cm by 3 cm. The bed was covered 50% with yellow and 50% pink granulated tissue. The right , measured approximately 6	A 025		

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A 025	Continued From page 8	A 025		

cm by 7 cm. The bed was covered 50% with black eschar and 50% yellow . The resident wore soft heel , an air mattress was on her bed and a cushion was in her wheelchair.

On at 3:34 PM, caregiver C said she turns and repositions the resident every hours.

On at 3:52 PM, the administrative assistant was asked to provide additional documentation to show measures put in place by the facility to prevent the initial development and now worsening of the resident's , . She said, "The administrator would know that."

Staff F provided a turning and repositioning schedule that started on and had times printed on the form. Review of it revealed staff did not indicate on the form that the resident was turned every two hours on through , , , , , , , , , , , , , and .

On at 3:39 PM, the facility's administrator said the resident's care was coordinated with hospice and health care provider, the resident was kept clean and dry at all times, turned, and repositioned every two hours and was applied each time the staff provided care. She said following the resident's on , staff B was counseled on providing care to the resident while she was in bed. All staff were educated on not leaving a resident unattended. If a resident was able to get out of bed, take them to the bathroom.

On at 4:05 PM, caregiver D said the training she received after the resident's was

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A 025	Continued From page 9	A 025		

that "it doesn't matter what position a resident , on butt, call her (administrator) right away. If , fill out a form." Regarding , interventions she said, "reposition her every two hours, always make sure she's dry, always put and on her."

Besides the incomplete turning and repositioning schedule, there was no facility documentation in the resident's record to indicate the facility implemented any proactive measures to both prevent the development and worsening of the ,

2. Resident #5's record revealed a 1823 assessment form that indicated the resident's diagnoses included , type 2, , , and a history of . The resident required total assistance with all ADLs and ambulated independently. She was alert, verbal, had and memory loss and was a risk.

An facility note indicated the resident was admitted to the facility and "The resident noted to be disoriented to time place and self. Resident is free from any , but does have several to arms, , and temple. Family confirmed these were from at previous facility. Resident is notably unstable upon ambulation."

A facility note read, "Admin received call from caregiver and sister around 10:30 AM. Resident was found lying on the floor on a comforter on in her room by sister. Admin spoke to several caregivers to investigate the situation. caregiver reported that caregiver left her like that. Admin terminated

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A 025	Continued From page 10	A 025		

caregiver and gave caregiver write up concerning situation. Admin request bed alarm for resident."

A at 11 AM facility note read, "Admin called family to discuss plan of action and family stated that resident was not walking correctly, and (emergency medical service) would be called. APRN notified."

A facility note read, "Admin received reports over weekend that resident was leaning to the right while walking. Nurse (hospice nurse) came to evaluate for . No visible signs. Plan to check middle during rounds with NP (nurse practitioner). Family and APRN notified. Admin received call around 10:30 that patient had a sit to floor and another to floor. Resident very restless. Admin discussed with family and NP that additional caregiver would come in and UA ( ) and labs to be taken. Put call out to (hospice) for help."

A facility note read, "Admin received call from caregiver that resident and did not hit her . Admin made call to sister and sister agreed to monitor for sample came negative for ( ). Still awaiting bloodwork to be done for NP to evaluate. APRN notified." There was no documentation to indicate facility specific post- interventions were implemented.

A facility note read, "Admin received text from sister that she would be picking up resident for lunch around 11:30 AM. Resident went with sister for 4 hours. Resident was brought with multiple cuts and scrapes on both left and right . Caregiver sent picture showing residents / . APRN aware. Daughter

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A 025	Continued From page 11 notified." A . . . . . facility note read, "Admin received call from caregiver that resident while trying to sit. Admin watched camera and saw resident hit the of her . Resident had on the area. Sister agreed to let paramedics take resident to the hospital. Resident received tests and scans all came . . . normal. NP aware." There was no facility documentation of interventions. A . . . . . hospital History and Physical indicated the resident was seen for a witnessed in which she hurt her . . . . She was discharged on the same date. A at 2 PM facility note read, "Admin received call from caregiver that resident in living room. Admin reviewed cameras and resident did not hit her . . . but leaned to the left and slid down. Sister agreed to monitor for . Some . . scabs from previous . . . . . ." There was no facility documentation of interventions. A at 3 PM facility note read, "Admin received call that resident again but hit her . . . this time. Noticeable bump on left side of forehead appeared. Sister agreed to a med change and to monitor again. Patient stable but unbalanced on . APRN suggested soft helmet." A . . . . . facility note read, "Caregiver called admin 6am to report resident . Resident in her room. Resident on her . . . and opened previous scabs. Admin made call to sister and agreed to have hospice come out to check and to monitor resident for the day. Sister	A 025		

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A 025	Continued From page 12 agreed to give ... once in the morning and once in the evening." There was no facility documentation of interventions. A ... at 3 PM facility note read, "Admin noticed resident ... and unbalanced when walking and reported to sister." A ... at 2 PM facility note read, "Resident tripped over family member and chipped front ... and open area. Sister, admin, and hospice at the scene. APRN made aware. Plan of action: give ... morning and night for 2 days, soft foods for the week, no ... brushing for the week, update family next day. Sister made an ... for ... with mobile ... fairy as front left ... was chipped and wiggly." There was no facility documentation of interventions. A ... at 8 AM facility note read, "Admin received call from caregiver that resident ... in the kitchen and hit her ... . The ... caused a gash on ... of ... with ... . Admin called sister and notified APRN. APRN instruct to give resident ... , ... twice daily until further notice for , ... Call hospice nurse out and monitor for ... and other abnormal symptoms or behaviors. APRN aware. Suggested to sister soft helmet again. Sister states she's getting recommendations from ... and will get it ordered." There was no documentation of interventions. An ... at 11 AM facility note read, "Hospice nurse eval-hold ... for two days. Vitals good, behaviors normal, symptoms normal. Used triple ... on ... gash. Wrapped with gauze. Went over with staff and hospice nurse if a rewrap is needed before Monday."	A 025		

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A 025	Continued From page 13 An hospice nurse's note read, "Patient continues to decline due to progression and potentially from multiple . Patient has become significantly slower over the past two weeks, with slow unsteady gait. Patient hangs downward leaning to the right and is high risk for . Occasional speech is incoherent with no meaningful interaction. Recent meeting with RNCM (registered nurse case manager), SW (social worker), and patient's sister to discuss plan of care. Patient's sister agrees to soft helmet and has been ordered from Medline-to be shipped directly from vendor. Patient's sister expresses many concerns with facility staff and appears that facility cannot meet current expectations. Sister considering transferring patient to new facility per conversation on . Plan to continue educating patient's sister, facility staff/administrator on progression and safety/ precautions." A at 7:45 AM facility note read, "Admin received call from staff that resident over while in a chair. Resident did not hit or and no injury apparent. Admin called sister to notify. Monitor resident today. APRN aware. Helmet was in use." There was no documentation of interventions. A facility note read, "Two No injury. No injury apparent. Family and APRN notified. Helmet was in use." There was no documentation of interventions. Aa at 11 AM facility note read, "Resident walking around living room area. Admin and staff nearby when took place. Resident tripped on and onto side table hitting near left was uncontrolled. Staff applied	A 025		

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	AL11968408	A. BUILDING: _____ B. WING _____	01/13/2023

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A 025	Continued From page 14 pressure on to stop . Admin called sister to see if sister wanted paramedics or hospice. Sister chose paramedics as was still and it looked like it needed stitches. Got under control. Paramedics arrived and took resident to hospital. APRN notified." There was no documentation of interventions. A hospital repair procedure note indicated a , 3 cm in length and 3 cm depth, was closed with five . The resident was discharged to the facility on the same date. A at 3:30 AM facility note read, "Admin received call from caregiver that resident in room unwitnessed and was on the of her . Admin called 911 and then called sister. Sister agreed for resident to go to hospital with ambulance. APRN aware." There was no documentation of interventions. A hospital report revealed an acute hematoma. A facility note read, "Admin attempted to contact family to request private duty care for continued residence at facility. Family did not respond." A facility note read, "Family reported that resident would not be returning to facility." On at 11:33 AM, any policies related to was requested of staff F, and she said the facility did not have any such policies. On at 1:59 PM, staff F said interventions for resident #5 were a mat, bed	A 025		

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A 025	Continued From page 15 alarm, every 2-hour checks on her at night, a soft helmet, try to supervise her while she walked, and encouraged her to sit down. On . . . . . at 3:26 PM, caregiver A said resident #5 "continuously walked and never sat down, when she walked, she just . ." The caregiver said that when the resident was in her wheelchair that she sometimes put her . . . on a wall and pushed against it with her , which caused the chair to tip backwards. She said sometimes a seat belt was placed on the resident while in her wheelchair, but the resident's sister did not want her in a wheelchair and wanted her to walk around. The caregiver said the resident "was not easy to work with, she was very difficult". She said when she was working in the kitchen she would watch the resident, who would right in front of her. On . . . . . at 3:34 PM, caregiver C said resident #5 had a wheelchair with a seat belt but the resident's sister did not want her to use a wheelchair. The caregiver said she worked 7 AM-6 PM, was by herself between 8 AM and 10 AM, and had to take care of all the residents and cook. She said at times she had to spend those two hours just with resident #5 because she was unsafe. On . . . . . at 3:39 PM, the facility administrator said the staff were supposed to keep an , on resident #5 at all times. She said a bed alarm was used, she was checked on every thirty minutes and if she wore shoes without grips or only socks staff were to put proper shoes on her. She said a camera was in the living room, kitchen, hallways, laundry and near the bathrooms and they continuously recorded. She then said, "I view the footage multiple times a day for 30 minutes to	A 025		

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A 025	Continued From page 16 one hour, as often as I can." The resident's only 1823 health assessment form indicated she was a risk. An facility admission note indicated she had , which her family said were as a result of a . The note also indicated she was notably unstable when ambulating. Subsequent to this, she experienced fourteen , some of which resulted in injuries and/or hospital visits, while in the facility and prior to her discharge on . Class II	A 025		
A 033 SS=D	59A-36.007(8) PHYSICAL . (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently	A 033		

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A 033	Continued From page 17 remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a physician prescribed a physical and that a written care plan was developed within 14 days for the use of the physical and prior to use for 1 of 7 sampled residents who was seen restrained at the time of the survey (#1). Findings: On at 8:53 AM, a female resident was seen sitting in a transport wheelchair in the facility's living room. A seat belt was attached to the wheelchair and fastened around the resident's waist. At 9:25 AM, caregiver A said the seat belt was used because if not, the resident would stand up and possibly . The caregiver then said the resident removed the belt herself at times. The surveyor asked the resident to unfasten the belt but, she only looked at the surveyor and did not make any effort to do so. At 9:35 AM, caregiver A was seen feeding the resident and the seat belt remained fastened around the resident's waist. Review of the resident's record revealed it did not contain any facility notes, no health care provider's order for the seat belt and no care plan that specified the following: 1. The device prescribed for use. 2. The maximum amount of time the resident is to have the applied each day; and,	A 033		

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A 033	Continued From page 18 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . At 10:15 AM, staff F said there were none of the required documents for use of the . At 10:32 AM, the resident was seen attempting to stand up from the wheelchair while the belt was still attached. The belt prevented her from fully standing. At 10:47 AM, the resident was seen using her to scoot the chair, as the brakes were engaged, to the kitchen counter where she attempted to use the counter to pull herself to a standing position. The belt prevented her from fully standing. At 11:25 AM, staff F and the administrative assistant both said they did not know a seat belt was being placed on the resident and so therefore there was no related documentation. Staff F said the facility did not allow the use of nor transport wheelchairs because they had the option to attach a belt. The administrative assistant retrieved a standard wheelchair and brought it to the resident. The assistant unfastened the belt and caregiver B walked with the resident to a sofa, where the resident sat down. At 11:33 AM, the surveyor requested any policies related to . Staff F said the facility did not have any because its protocol was that no were allowed.	A 033		

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A 033	Continued From page 19 At 1:05 PM, the resident was seen repeatedly standing up from the wheelchair. One of the facility's staff members had to remain at her side since the belt was removed. The resident became easily agitated with their presence and attempts to redirect her. Her gait was unsteady. On at 3:39 PM, the administrator said regarding the resident's use of the seat belt, "I was unaware the girls (caregivers) were utilizing it. The girls were instructed not to use it because it came with her wheelchair." On at 4:05 PM, caregiver D said the seat belt was used on the resident "because she likes to get up. If we're with another resident, we put the seat belt on her cause she's a risk." When asked if she ever removes the belt she said, "I take it off probably like when I'm near her and when I'm feeding her." Review of the resident's record revealed a facility admission date of and an 1823 health assessment form dated the same indicated her diagnoses was of the , , and with . She was alert with , cognition, required cueing/reminders and redirection. She was a risk for with a history of , needed assistance with all ADLs and transferring, and received hospice services. A hospice/assisted living facility integrated plan of care did not indicate use of a seat belt. The resident's residency agreement indicated the following risk disclosure: "the risk of falling we are not legally able to restrain a	A 033		

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A 033	Continued From page 20 resident to their bed, their wheelchair etc. and therefore the risk of or even a with injury may and sometimes does occur." Class III	A 033		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to develop policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device, and failed to	A 034		

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A 034	Continued From page 21 document the use of half-side rails in 2 of 7 sampled resident's record (#2 & #3). Findings: 1. Resident #2's record revealed he was admitted to hospice services on . The integrated plan of care dated the same did not address the side rails. An 1823 health assessment form indicated his diagnoses included , , and . He was a high risk and required assistance with all ADLs and transferring. On at 9:10 AM, resident #2 was seen awake and lying in his bed. He said, "everything's fine". The left side of his bed was against the wall and half side rails were in the up position. The right-side rail did not obstruct the resident from being able to exit the bed. The resident's record did not document the use of the side rails. 2. Resident #3's record revealed a 1823 health assessment form indicated her diagnoses included Major , , and 's . She was alert and oriented to person, place, and time. On at 9:14 AM, resident #3 was seen in her bed with her closed. The right side of her bed was against the wall and half side rails were in the up position. The left rail was positioned in the middle of the bed. On at 11:33 AM, a request was made to review the facility's policies and procedures on assistive devices. At 11:40 AM, staff F said the	A 034		

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A 034	Continued From page 22 facility did not have related to assistive devices. On [redacted] at 11:50 AM, resident #3 said staff had to help her reposition in bed and that she used the rails to help herself do so. On [redacted] at 1:15 PM, resident #2 said he used the rails to help himself turn in the bed. On [redacted] at 1:57 PM, staff F confirmed there was no documentation. Class III	A 034		