STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A389	A. BUILDING _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEBSTER HEALTH SERVICES NURSING FACILTY	70 MEDICAL PLAZA EUPORA, MS 39744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 1/23/24 to 1/25/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F 700 for failure to ensure the safety of a resident using side rails. The census at the time of the survey was 34 and the facility is licensed for 36 beds.	F 000		
F 700 SS=G	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700		2/20/24

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

Electronically Signed | 02/15/2024

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F 700	Continued From page 1 by: Based on observation, staff interview, record review, and facility policy review the facility failed to ensure the safety of a resident when bilateral side rails were applied to the middle of a residents' bed without assessing the resident for alternative safety methods, risk for entrapment, and failed to obtain informed consent prior to installation of bedrails for one (1) of three (3) residents reviewed. Resident #6. Findings include: A review of the facility policy titled, "Side Rails," revised June 14, 2023, revealed "Rationale: To provide guidelines for safe and effective use of bed rails in the patient care environment..." An observation of Resident #6's room on 1/23/24 at 10:30 AM, revealed side rails in the up position bilaterally on each side of the bed. An observation of measurements taken of Resident #6's bed and side rails by the maintenance staff on 1/24/24 at 2:00 PM, revealed the bed mattress length measurement was 79 inches long. The length of the open space from the headboard to the top of the rail and bottom of the rail to the foot board measured 26 inches long respectively, and the side rails bilaterally measured 26 ½ inches long. The bed rails were bilaterally in the middle of the bed. An observation on 1/24/24 at 9:00 AM, revealed bilateral side rails up in the middle of Resident #6's bed, with a padding noted to top of the first bar of the side rail, with the two bars below observed to have no padding, and the two lateral bars on the side rails had no padding. Resident is	F 700	" On January 24, 2024, Director of Nursing added padding to the bottom bars of the bed rails to coincide with padding on the top bars. On January 24, 2024, Director of Nursing completed a bed rail utilization assessment to assess Resident #6 for risk of entrapment. Resident #6 was found to be at increased risk of entrapment due to low body weight and impaired cognition. On January 24, 2024, Resident #6□s bed and mattress were measured by Facility Operations employee and Surveyor. Bed rails cannot be moved due to design of the bed; however, facility is willing to replace bed should Resident #6□s family change their position regarding the bed rail use. Measurements were from the top of the rail to the headboard and from the bottom of the rail to the footboard were 28 inches long respectively. Bed□s dimensions were determined to be appropriate for Resident #6□s height and weight (61 inches and 92.4 pounds). On January 24, 2024, Director of Nursing discussed risks versus benefits of bed rails with resident□s responsible party. After education related to entrapment risks, Resident #6□s responsible party insisted on bed rails remaining and signed an attestation (Attachment 1) that education had been done and giving consent for bed rails to remain on the bed, despite increased risk for entrapment. On January 24, 2024, Quality Assurance	

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F 700	Continued From page 2 observed sticking her arms into the side rails. A record review of the Skin Tear Report dated 10/9/23 for Resident #6 revealed, "bleeding from right leg, three (3) skin tears noted two (2) cm (centimeters) x 0.5 cm, (1) one cm x (1) one cm moon shaped, and 0.2 cm x 0.2 cm. Blood was noted on the right side bed rail, orders to clean skin tears with normal saline (NS), pat dry, apply steri-strips, cover with telfa, wrap with gauze dressing." A record review of Skin Tear Report for Resident #6 dated 1/08/24, revealed "CNA (Certified Nurse Assistant) reported when she entered room, resident had legs over the side of the head of the bed (HOB), blood was noted on the sheets, skin tear noted behind left knee ...Resident has issues with skin tears due to fragile skin related to leukemia and trying to get out of the bed." A record review of the Skin Tear Report dated 1/23/24 for Resident #6, revealed "CNA reported while getting resident dressed for bed she was hitting at staff and hit the bed rail, skin tear occurred, triangle in shape, two (2) cm on each side...skin tear to arm...they gently tried to remove her arm from side rail..." An interview with Licensed Practical Nurse (LPN) #1 on 1/24/24 at 10:00 AM, she revealed she cares for Resident #6 often and revealed she often attempts to get out of the bed, resists care at times, and has hit her arms and legs on the side rails causing skin tears because she is so small, and her skin is thin and fragile. LPN #1 confirmed Resident #6 obtained a skin tear on 1/23/24 when she began hitting at staff and hit her right arm on the side rail causing a skin tear.	F 700	and Performance Improvement Committee was made aware and the Interdisciplinary Team discussed other options besides bed rails for Resident #6. Team considered mattress to be placed on floor or a new bed without rails to be ordered. Physical Therapy Director evaluated resident for positioning options; however, he recommended continuing to utilize the existing bed rails. He recommended adding protective covering to side rails to reduce skin tears and the risk for entrapment. Interdisciplinary Team discussed and agree with recommendation. Geri-sleeves were also ordered for Resident #6. On February 2, 2024, geri-sleeves were applied to resident for additional protection against side rails. On February 15, 2024, Director of Nursing added new custom protective covering to side rails to reduce likelihood of skin tears from resident hitting side rails. " All residents have the potential to be affected by this deficient practice. " On January 24, 2024, Bed Rail Consent was added to the Facilities Admission Packet to ensure that all new residents and responsible parties are educated on the potential risk and benefits of bed rails as well as alternatives to be considered. On February 13, 2024, Quality Assurance and Performance Improvement Committee reviewed and revised	

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F 700	Continued From page 3 An interview with CNA #2 on 1/24/24 at 10:20 AM, reported that Resident #6 is very active and always moving around. She confirmed she has observed Resident #6 with her legs and feet over the side rails and sometimes her hands and arms have been in between the the side rail bars. An interview with CNA #1 on 1/24/24 at 10:30 AM, revealed she has not cared for Resident #6 when she actually obtained a skin tear, but she has reported to multiple staff that the resident attempts to get out of bed throwing her arms and legs over the side rails. She has also had her arms between the bars on the side rails which she was able to easily remove without injuring the resident. An interview with the Director of Nursing (DON) on 1/24/24 at 11:00 AM, revealed she was unable to find any side rail assessments for safety, risk of entrapment, any alternative methods attempted prior to use of the side rails, or a consent for use of the side rails for Resident #6. She confirmed Resident# 6 has had multiple skin tears related to hitting her arms on the side rails. She confirmed after review of the Skin Tear Reports the reports dated 10/9/23 skin tears times three to right lower leg, 1/08/24 skin tear behind left knee, and 1/23/24 skin tear to right forearm were from Resident #6 hitting/bumping her extremities on the side rails. The DON then revealed the resident does have padding to the side rail to help prevent skin tears but confirmed the resident was still at risk for receiving skin tears because the entire side rail was not padded and confirmed the resident was at risk for entrapment in getting her arms and legs caught between the the rails and could possibly come over the rails and fall.	F 700	facility□s Side Rail Policy. Revisions include changes in assessment timing and evaluation intervals as recommended by TMF Health Quality Institute (Attachment 2). Side Rail Assessment has also been added to Facilities Admission Packet so that every resident will have an initial assessment during admission. Education on bed rail safety was approved by Director of Nursing and Facility Educator on February 13, 2024. Education consist of video addressing bedrail safety related to entrapments, falls, and other risk. Education was assigned to all nursing staff on February 13, 2024, through facilities computer based training program which generates documented completion. Nursing staff was made aware per Director of Nursing to complete this computer based training by February 21, 2024. Any staff not scheduled prior to this date are required to complete on next scheduled shift. Beginning February 8, 2024, Facility Operations staff member and Charge Nurse administered bed rail assessments, measured all beds, and completed checklist for all resident beds. No equipment concerns, repairs, or additional entrapment risks were identified for residents other than Resident #6. " Beginning February 8, 2024, nursing staff will complete bed rail checklist quarterly for each resident utilizing bed rails or with a significant change in	

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F 700	Continued From page 4 Record review of the resident information form revealed the facility admitted Resident # 6 on 9/18/2023 with diagnoses including Unspecified Dementia, Unspecified severity without behavior/psych/mood, and Anxiety. Record review of the quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 12/25/23, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated that she was severely cognitively impaired. Section K revealed Resident #6 was 61 inches in height and weighed 98 pounds.	F 700	resident condition to evaluate residents risk of entrapment and bed condition. Any equipment issues identified will be reported to Facility Operations immediately. If assessment shows new or increased risk for entrapment, Director of Nursing, Administrator, and/or charge nurse will be notified immediately for appropriate intervention. Director of Nursing will review all new admissions for the next 12 months, beginning February 8, 2024, to ensure bed rail consent and assessments are in compliance. Director of Nursing will review a minimum of 10 resident records quarterly, beginning March 1, 2024, to ensure bed rail assessment has been completed. Director of Nursing will review all residents with a significant change in conditions for the next 12 months, beginning February 8, 2024, to ensure residents have been evaluated for risk of entrapment and bed condition. Bed rail consent and assessment data collected by Director of Nursing will be reviewed at least quarterly by the Quality Assurance and Performance Improvement Committee for 12 months beginning February 13, 2024, or until facility has 100% compliance with completion for 3 consecutive quarters.	