STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. BUILDING _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

(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 Recertification Survey and Compliant Investigation (CI), MS #20693, at the facility from 3/20/23 through 3/23/23. The SA investigated the complaint regarding Admission, Transfer, and Discharge rights and there were no citations related to the complaint. During the survey, the facility was found not to be in compliance with the requirements of participation in Medicare and Medicaid and cited F623, F656, F700, and F880. The facility had a census of 113 and was licensed for 120 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		5/5/23

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

Electronically Signed | 04/17/2023

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F 623	Continued From page 1	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to provide written notification of a transfer/discharge to a resident, the Resident Representative (RR), and the Office of the State Long-Term Care	F 623	1 Written Notice of Transfer for Resident #89 was sent on 03/22/2023 to the Ombudsman and the Resident Representative regarding the transfer on 01/30/2023.	

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F 623	Continued From page 3 Ombudsman, when a resident was transferred to a local acute hospital for one (1) of six (6) residents reviewed. (Resident #89) Findings include: A record review of the facility's policy, "Notice Requirements Before Transfer/Discharge", revised 9/2022, revealed, "The facility will notify the resident and resident's representative(s) before a transfer or discharge ...in writing ...The facility will send a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman ..." Record review of the medical record for Resident #89 revealed there was no written notification of a transfer or discharge for the resident or the RR when Resident #89 was transferred to the hospital on 1/30/23. Record review revealed of the "Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman" for January 2023, revealed Resident #89 was not listed as being transferred from the facility. During an interview on 03/22/23 at 04:13 PM, the Social Worker (SW) confirmed that the written notification of transfer/discharge and the copy of the notice to the Ombudsman fell through the cracks and wasn't completed when Resident #89 went to the hospital in January. She stated that the written notification should always be completed when a resident is transferred or discharged from the facility. During an interview on 03/23/23 at 08:05 AM, the Administrator (ADM) revealed that when a	F 623	2 Any resident who is transferred or discharged has the potential to be affected. 3 A Facility□s Admissions, Transfer, and Discharge Policy was reviewed on 04/10/23 by the Administrator, Social Services Director, and Social Services Assistant to ensure Policy was being followed. B The Census/Transfer List will be checked daily by Social Services beginning on 04/12/2023 and printed weekly to go with the Transfer Log, to ensure a resident is not omitted from the transfer log to the Ombudsman and written notice is sent out per requirement. This will be ongoing. (see attached Transfer Log) C Social Services Employees were in-serviced by Administrator on 03/22/23 the Facility□s Admissions, Transfer, and Discharge Policy 4 The audit findings will be reviewed monthly for three months with the Quality Assurance committee to ensure continued compliance beginning May 4, 2023. A Social Services Director will review the Census/Transfer Log each day beginning on 04/12/2023 and monthly before it□s sent to the ombudsman after audited by the Administrator. B Administrator will pull Admission/Discharge Report monthly, beginning April 2023 to compare to Transfer/Census Log to ensure all Transfers have been included.	

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F 623	Continued From page 4 resident is transferred to the hospital, the facility notifies the family and provides them with a written notice of the transfer, and the Ombudsman is also informed. Record review of the "Face Sheet" revealed Resident #89 was admitted by the facility on 1/17/2023 with diagnoses that included Non-Pressure Chronic ulcer of the Right Foot and Type 2 Diabetes Mellitus with Foot Ulcer. Record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/23 revealed Resident #89 discharged from the facility on 1/30/23 to an acute hospital.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		5/5/23

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F 656	Continued From page 5 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to implement the comprehensive care plan related to a resident's bed side rails for one (1) of 26 care plans reviewed. Resident #12 Findings include: A record review of the facility's policy titled "DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN", revised 9/2022, revealed, "The facility will ...implement a comprehensive	F 656	1 Resident #12□s bed rails were corrected on 03/23/23 by Safety Nurse to follow the Care Plan. 2 All Residents with bed rails have the potential to be affected. 3 A Facility□s Comprehensive Resident Centered Care Plans Policy was reviewed by Administrator, Safety Nurse, and DON on 04/10/2023. No revisions were necessary. B Direct Care employees were in-serviced on Facility□s Comprehensive	

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F 656	Continued From page 6 person-centered care plan for each resident ...that includes measurable objectives ...to meet the resident's ...needs that are identified in the comprehensive assessment. The comprehensive care plan must describe ...1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ...". A record review of the Comprehensive Care Plan, review date of 3/21/23, with a care plan goal of "I want to be kept clean, dry and my needs met" revealed an intervention with a start date of 9/15/22 of "I need my left side rail up as an enabler". An observation and interview with Resident #12's son on 03/20/23 at 1:30 PM, revealed the 3/4-length side rails were raised on both sides of the bed. The son confirmed that both side rails have been on his mother's bed since she was admitted to the facility. He stated he was not sure why she had them on the bed unless it was to prevent falls. An observation and interview with Certified Nursing Assistant (CNA) #1 on 03/21/23 at 3:12 PM, revealed Resident #12's side rails were raised on each side of the bed. CNA #1 explained that the resident needed them because she was at a high risk for falls. CNA #1 further explained that she would read the care plan on the Kiosk to find out if a resident required side rails. During an observation, interview, and record review with Licensed Practical Nurse (LPN) #2 on 3/21/23 at 3:30 PM, she acknowledged that Resident #12's bed had both 3/4-length side rails	F 656	Resident Centered Care Plans Policy by Administrator beginning on 04/12/2023 and will continue until completed. 4 The audit findings will be reviewed by the Director of Nurses with the Quality Assurance committee for three months to ensure continued compliance beginning on May 4, 2023. A Daily Bedrail/Care Plan Audit was put in place on 04/12/2023 by the Director of Nursing to monitor 10 Residents for correct bedrail positioning daily for 2 weeks, then monthly for 2 months, and then quarterly to ensure Care Plan has been followed. (see attached Daily Bed Rail/Care Plan Audit)	

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F 656	Continued From page 7 raised, instead of just the left one as required per the comprehensive care plan. LPN #2 confirmed that staff were not following the plan of care by having both side rails raised. During an interview and record review of the Comprehensive care plan with the Director of Nursing (DON) on 3/22/23 at 8:33 AM, she verified that the care plan intervention required that the left side rail be up as an enabler for Resident #12 and if both side rails were up, then the staff were not following the plan of care. Record review of the Face Sheet revealed the facility admitted Resident #12 on 9/15/22 with medical diagnoses that included Anxiety Disorder, Glaucoma, and Major depressive disorder. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/3/23 revealed Resident #12 required extensive assistance with bed mobility.	F 656		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident	F 700		5/5/23

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F 700	Continued From page 8 representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review, the facility failed to attempt the use of alternatives to bedrails prior to the installation of bedrails for six (6) of twenty-one residents reviewed. (Residents #8, #11, #12, #40, #50, and #55) Findings include: A review of the facility's policy, "'Bedrails", revised 9/2022, revealed, "The facility will attempt to use appropriate alternatives prior to installing a side to bedrail...8. If no appropriate alternative is identified, the medical record would have to include evidence of the following. a. The purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful...10. If bed rails are not appropriate for the resident and the facility keeps the bed rail on the bed, but in the down position, raising the rail even for episodic use during care will be considered noncompliance if all the requirements (assessment, informed consent, appropriateness of bed, and inspection and maintenance) are not met prior to the episodic bedrail use for the resident."	F 700	1 Residents #8, #11, #12, #40, #50, #55 had bed rails discontinued and alternatives (bed in low position, wedges, pillows, trapeze bar) were put in place. Resident #8 alternatives failed and 2 quarter bed rails placed on 03/30/2023. 2 All residents with bed rails have the potential to be affected. 3 A All residents with bed rails were assessed by the Safety Nurse, DON, ADON, and MDS nurses for alternatives in place of long bed rails. B After all residents were assessed for the use of alternatives to bed rails, all direct care employees were in-serviced on 04/12/2023 by Administrator, Director of Nursing, and Safety Nurse on the proper use of alternatives prior to using bed rails. C After all were assessed for the use of alternatives to bed rails, direct care employees were in-serviced on Facility□s Bed Rail Policy, Consent for Use of Bed Rail, Daily Bed Rail/Care Plan Audit, and Bed Rail Assessment by Administrator, Safety Nurse, and DON beginning on 04/12/2023 will continue until completed. D The Safety Nurse will assess all new admissions for the proper	

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F 700	Continued From page 9 Resident #8 During an interview on 3/21/23 at 12:15 PM, with CNA #4, she stated that Resident #8 used to try to get out of the bed, so the staff raised her bedrails. She explained that the resident used to be able to help turn herself in bed, but she was not able to do that anymore, and she had not attempted to get out of bed in a long time. An observation and interview on 3/21/23 at 3:00 PM, with Registered Nurse (RN) #1, revealed Resident #8 had two (2) full-length bedrails raised. RN #1 stated that previously the resident was able to help the staff turn while in bed, but now she is unable to assist. An interview on 3/21/23 at 4:40 PM, with Licensed Practical Nurse (LPN) Restorative Coordinator (RC), she revealed that when Resident #8 was admitted by the facility, she used the bedrails as an enabler, but now she was unable to assist in turning or repositioning herself. She confirmed that Resident #8 did not attempt to get out of bed and had not experienced any falls from the bed. She stated that the resident has had two full - length bedrails raised in bed since she was admitted and that no alternative to bedrails had been attempted. She said that she realized that since the resident's ability to assist in turning and repositioning had changed since admission, the bedrail evaluation should have reflected the change. An interview on 3/22/23 at 10:10 AM, with LPN #1 revealed that Resident #8 would not be able to lower her own bedrails. An observation on 3/22/23 at 3:05 PM, revealed	F 700	alternatives to bed rails beginning 04/11/2023. 4 The audit findings will be reviewed monthly for three months by the Safety Nurse with the Quality Assurance committee to ensure continued compliance beginning May 4, 2023. A Daily Bedrail/Care Plan Audit was put in place on 04/12/2023 by the Director of Nursing or Designee to monitor 10 Residents for correct bedrail positioning daily for 2 weeks, then monthly for 2 months, and then quarterly. (see attached Daily Bed Rail/Care Plan Audit)	

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the Maintenance Director measured the bedrails for Resident #8 and they were 65 inches long.

Record review of the "Face Sheet" revealed the facility admitted Resident #8 on 4/30/19 with medical diagnoses that included Alzheimer's Disease and Muscle Weakness.

Record review of the "Physician Orders" for the month of March 2023, revealed Resident #8 had a Physician's Order dated 4/30/19 for "Side rail(s) up x (times) 2 as an enabler."

Record review of the "Side Rail Evaluation", dated 03/16/23, indicated that Resident #8 was not at risk for getting out of bed, did not have a history of falls, used the side rails and/or alternative for positioning or support, and the type of side rails used was marked as "Left", "Right", and "3/4 rails."

Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/21/22 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated she had severe cognitive impairment. Further review revealed Resident #8 required extensive assistance with bed mobility, and restraints used in bed (bed rail) were not used.

Resident #11

An observation on 3/20/23 at 02:50 PM, revealed Resident # 11 was lying in bed and had two (2) full-length bedrails that were raised on both sides of the bed.

In an observation and interview on 3/21/23 at

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11:30 AM, with CNA #5, she confirmed that Resident #11 had "long" bedrails that were raised on both sides of the bed, and that they had always been on the bed. She stated that the resident used to be able to get out of the bed by herself, but now required help.

During an observation and interview on 3/21/23 at 03:45 PM, with LPN #1, she stated that Resident #11 had full-length bedrails that were raised to help with bed mobility and to prevent falls. She said Resident #11 could not move around in the bed by herself and would not be able to lower the bedrails on her own.

In an interview on 3/21/23 at 04:15 PM, with the LPN RC, she stated that the facility would use bedrails for a resident if the resident and/or a family member requested their use. A side rail consent form was signed on admission, and the resident or the Resident Representative (RR) were made aware of the potential risk of the side rails by reading and signing the side rail consent form that listed the benefits and potential risks. She stated that even when a resident was cognitively impaired, she still asked the resident, and/or the family member if they wanted bedrails. She confirmed that she had not tried any other interventions other than bedrails but realized that she should have. She said that Resident #11's RR requested that side rails be used to assist with bed mobility and to define the parameters of the bed. She confirmed that Resident #11 could have benefited from the use of one-half (1/2) bedrails, but the facility did not have any.

During an interview and observation with the LPN RC on 03/22/23 at 02:15 PM, she reported that Resident #11 had 3/4-length bedrails and that she

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distinguished 3/4-length from full-length side rails because she understood that full-length side rail began at the headboard and extended to the footboard with no space between. Upon observation, she confirmed that Resident #11 did have full-length side rails on both sides of the bed and confirmed that the side rails would prevent the resident from getting out of the bed. She also confirmed that Resident #11 should not be able to lower the bedrails and that she was aware that side rails could be a restraint after reading the guidelines today.

An observation on 3/22/23 at 3:05 PM, revealed the Maintenance Director measured the bedrails for Resident #8 and they were 65 inches long.

Record review of the "Facesheet" revealed the facility admitted Resident #11 on 10/09/21 with medical diagnoses that included Alzheimer's Disease and Unspecified Dementia.

Record review of the "Physician Orders List" revealed Resident #11 had a Physician's Order dated 10/9/21, fir "Side Rails Up x 2 As Enabler)."

Record review of the "Side Rail Evaluation", dated 02/14/23, indicated that Resident #11 was not at risk for getting out of bed, did not have a history of falls, used the side rails and/or alternative for positioning or support, and the type of side rails used was marked as "Left", "Right", and "3/4 rails."

Record review of the Quarterly MDS with an ARD of 2/13/23 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated she had moderate cognitive impairment. Further review revealed Resident

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#11 required extensive assistance with bed mobility.

Resident #12

An observation on 3/20/23 at 10:30 AM, revealed Resident #12 had 3/4-length bed rails that were raised on both sides of the bed.

An observation and interview with Resident #12's son on 03/20/23 at 1:30 PM, revealed the 3/4-length side rails were raised on both sides of the bed. The son confirmed that both side rails have been on his mother's bed since she was admitted to the facility. He stated he was not sure why she had them on the bed unless it was to prevent falls.

An observation and interview with Certified Nursing Assistant (CNA) #1 on 03/21/23 at 3:12 PM, revealed Resident #12's side rails were raised on each side of the bed. CNA #1 explained that the resident needed them because she was at a high risk for falls. She further explained that using bedrails was a concern because the resident could climb over the rail and fall or become injured by getting her arms caught in the rails. CNA #1 asked Resident #12 if she could lower the bedrails and she said, "No."

During an observation, interview, and record review with Licensed Practical Nurse (LPN) #2 on 3/21/23 at 3:30 PM, she acknowledged that Resident #12's bed had both 3/4-length side rails raised. LPN #1 commented that the possible complications related to the improper use of bedrails with a resident with cognitive issues included falling over the rails, becoming entrapped in the rails, and receiving skin tears.

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LPN #1 confirmed that although Resident #12 could grab the bedrail, she was unable to assist with bed mobility and was unable to lower either side rail.

During an interview with the LPN RC on 3/22/23 at 02:03 PM, she confirmed that Resident #12 could not lower the bedrails and confirmed that the bedrails were a restraint.

An observation on 3/22/23 at 3:05 PM, revealed the Maintenance Director measured the bedrails for Resident #12 and they were 55 1/2- inches long.

Record review of the Face Sheet revealed the facility admitted Resident #12 on 9/15/22 with medical diagnoses that included Anxiety Disorder, Glaucoma, and Major depressive disorder.

A record review of the "Physician Orders" for the month of March 2023, revealed a Physician's Order dated 9/15/22 for "Side Rails Up x 1 on Left as Enabler."

Record review of the "Side Rail Evaluation", dated 3/3/23, indicated that Resident #12 was not at risk for getting out of bed, did not have a history of falls, used the side rails and/or alternative for positioning or support, and the type of side rails used was marked as "Left" and "3/4 rails."

A record review of the Quarterly MDS with an ARD of 3/3/23 revealed Resident #12 had a BIMS score of 8, which indicated she had moderate cognitive impairment. She also required extensive assistance with bed mobility.

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F 700	Continued From page 15 Resident #40 An observation on 03/20/23 at 11:38 AM, revealed Resident #40 was lying in bed with full-length length bedrails raised on both sides. An observation and interview on 3/21/23 at 11:37 AM, CNA #4 revealed that Resident #40 had two (2) full-length bedrails on her bed. She explained that when the resident was first admitted to the facility, she tried to get out of bed, but admitted that she had not tried lately. An observation and interview on 3/21/23 at 3:15 PM, with RN #1, she confirmed that both bedrails for Resident #40 were raised and were full-length. She commented that previously the resident helped the staff during turning and repositioning, but she was no longer able to help. She explained that the resident is stiff and does not move around while in the bed. She stated that bedrails were considered a restraint if the resident did not need them. An observation on 3/22/23 at 3:09 PM, revealed the Maintenance Director measured the bedrails for Resident #40 and they were 65 inches long. An interview on 3/21/23 at 4:29 PM, with the LPN RC, revealed that Resident #40 was able to assist with turning and repositioning on admission, but now she is no longer able to assist. She revealed that when the resident's functional status changed, her side rail evaluation should have reflected the change. She stated that Resident #40 had a side rail evaluation completed on admission and quarterly. She verified that Resident #40 had two full-length side rails up while in bed that had been in place since	F 700		

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her admission and no alternative had been attempted.

An interview on 3/22/23 at 9:30 AM, with LPN #1 revealed that Resident #40 could not lower the bedrails by herself.

Record review of the "Face Sheet" revealed the facility admitted Resident #40 on 9/7/21 with medical diagnoses that included Chronic Atrial Fibrillation and Unspecified Sequelae of Cerebral Infarction.

Record review of the "Physician Orders" for the month of January 2023, revealed Resident #40 had a Physician's Order dated 9/8/21 for "SR (Side rail) x 2 used for enabler."

Record review of the "Side Rail Evaluation", dated 01/31/23, indicated that Resident #40 was not at risk for getting out of bed, did not have a history of falls, used the side rails and/or alternative for positioning or support, and the type of side rails used was marked as "Left", "Right", and "3/4 rails."

Record review of the Quarterly MDS with an ARD of 1/30/23 revealed Resident #40 had a BIMS score of 4, which indicated she had severe cognitive impairment. Further review revealed Resident #40 was dependent upon staff for bed mobility, and restraints used in bed (bed rail) were not used.

Resident #50

An observation on 3/20/23 at 2:10 PM, revealed, Resident #50 lying in bed with full-length side rails raised on both sides.

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In an observation and interview on 3/21/23 at 11:25 AM, with CNA #5, she confirmed that Resident #50 did have "long" bedrails that were raised, and she had always had them. She stated that Resident #50 previously could get out of bed by herself, but now required assistance.

An interview and observation on 3/21/23 at 3:40 PM, with LPN #1, she stated that Resident #50 had full side rails to assist with turning and to prevent falls, but she did not move around and would not be able to lower the side rail on her own.

During an interview and observation with the LPN RC on 3/21/23 at 02:20 PM, she confirmed that Resident #50 had full-length bedrails raised on both sides of the bed and confirmed that the side rails prevented the resident from getting out of bed. She also confirmed that Resident #50 could not lower the bedrails. She revealed the purpose of Resident #50's side rails were to serve as an enabler for bed mobility and that she had not tried any other interventions, but realized she should have.

In an interview on 3/21/23 at 04:05 PM, with the LPN RC, she revealed that Resident #50 used the bedrails to assist with bed mobility and to define the parameters of the bed and that the resident could benefit from 1/2 side rails.

An observation and interview on 3/22/23 at 8:25 AM, revealed, Resident #50 lying in bed with full-length side rails noted on both sides of the resident's bed. Resident stated that she wanted the bedrails to "stay up."

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An observation on 3/22/23 at 3:09 PM, revealed the Maintenance Director measured the bedrails for Resident #50 and they were 65 inches long.

Record review of the Face Sheet revealed Resident #50 was admitted by the facility on 03/21/2016 with medical diagnoses that included History of Falling and Unspecified Dementia.

Record review of the "Physician Order List" revealed a Physician's Order dated 3/21/16 for Resident #50 for "Side Rails Up X 2 As Enabler."

Record review of the "Side Rail Evaluation", dated 01/24/23, indicated that Resident #50 was not at risk for getting out of bed, did not have a history of falls, used the side rails and/or alternative for positioning or support, and the type of side rails used was marked as "Left", "Right", and "3/4 rails."

Record review of the Significant Change of Status MDS with an ARD of 1/23/23 revealed Resident #50 had a BIMS score of 5, which indicated she had severe cognitive impairment. Further review revealed she was dependent upon staff for bed mobility.

Resident #55

In an observation on 03/20/23 at 01:55 PM, Resident #55 was lying in bed. He had an upper and lower bedrail raised on the right side of the bed and his bed was positioned against the left wall.

In an interview on 03/21/23 at 11:30 AM, with Resident #55's wife, she stated the staff raised the side rails so the resident could grab it when

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staff are turning and changing him, and the side rails helped him to not get out of the bed.

In an interview on 03/21/23 at 11:40 AM, CNA #6 revealed that she was unsure if Resident #55 had ever tried to get out of bed, but he required his bedrails to be raised when he was in bed to keep him safe.

In an interview on 03/21/23 at 02:30 PM, with the LPN RC revealed Resident #55 had a Physician's Order for two right (2) half side rails to help with positioning. She stated that he was on a turning program where he was turned every two hours while he was in bed and he attempted to throw his foot off the bed when he was anxious. She confirmed that Resident #55's left side of the bed was against the wall and both bedrails on the right side of the bed were raised. She confirmed the bottom rail should not be raised because the resident could get a bruise or get his leg caught in the railing. She revealed she wasn't sure why the lower rail was on the bottom of the right side of the bed.

Record review of the Face Sheet revealed the facility admitted Resident #55 on 1/5/2022 with diagnoses that included Sequelae of Cerebral Infarction and Hemiplegia and Hemiparesis following Cerebral Infarction.

Record review of the "Physician Orders List" revealed a Physician's Order dated 1/5/22 for Resident #55 for "SR Up x 2 As An Enabler."

Record review of the "Side Rail Evaluation", dated 03/17/23, indicated that Resident #55 was not at risk for getting out of bed and used the side rails and/or alternative for positioning or support,

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F 700	Continued From page 20 and the type of side rails used was marked as "Left", "Right", and "half rails." Record review of the Quarterly MDS with an ARD of 03/16/2023 revealed Resident #55 had a BIMS score of 99, which indicated the resident has a severe cognitive impairment. Further review revealed he required extensive assistance with bed mobility. An interview with the Director of Nursing on 03/21/23 at 4:00 PM, revealed that 3/4-length bedrails, full-length bedrails, and four (4) half bedrails could be considered a restraint and residents could climb over or become entrapped. An interview with the Administrator on 03/21/23 at 4:05 PM, revealed residents with full-length, 3/4-length rails and (4) half bedrails were at risk for over the rails and had an increased risk of injury.	F 700		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		5/5/23

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F 880	Continued From page 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 22 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to prevent the possible spread of an infection by staff not disinfecting a mechanical lift (shared equipment) between resident use for one (1) of four (4) days of survey. Findings Include: Record review of the facility's policy, "Infection Control", revised 9/2022, revealed, "...The facility has developed and implemented written policies and procedures for the provision of infection prevention and control ...These ...policies and procedures include ...Routine cleaning and disinfection of resident care equipment including equipment shared among residents ..." An observation on 3/21/23 at 2:00 PM, revealed Certified Nurse Aide (CNA) #1 walked out of Resident #58's room with a mechanical lift and immediately took the lift into Resident #31's room. CNA #1 did not clean or disinfect the mechanical lift between resident rooms. An interview on 3/21/23 at 2:10 PM, with CNA #1	F 880	1 Lift being used by CNA #1 for Resident #58 and Resident #31 was cleaned on 03/21/2023 by CNA #1. 2 All Residents who use lifts have the potential to be affected. 3 A In-Service was done by Infection Prevention Nurse beginning on 03/21/2023 for Direct Care Employees per facility policy on cleaning of Multi-Use Equipment and will continue until completed. B Multiple cleaning wipe dispensers were mounted throughout the facility on beginning on 03/31/2023 and completed on 04/08/2023 by Maintenance to allow disinfecting wipes for lifts to be more centrally located for staff to access for ease of cleaning lifts. C A Root Cause Analysis was completed on proper cleaning of multi-use equipment on 04/17/2023 by the Administrator with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement committee and Governing Body. D Resident care staff and	

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F 880	Continued From page 23 revealed she used the mechanical lift on an unsampled resident when she transferred the resident to bed. She stated that she knew she was supposed to clean the mechanical lift in between resident use but admitted that she did not. She verified that she should have cleaned the lift with the (Proper Name of germicidal bleach) wipes that the facility provided to prevent the spread of germs. An observation on 3/21/23 at 2:25 PM revealed CNA #2 and CNA #3 exited Resident #31's room with the same mechanical lift. An interview on 3/21/23 at 2:28 PM, with CNA #2 and CNA #3, confirmed that CNA #1 had brought the mechanical lift to them, and they used it to assist Resident #31 to bed. They acknowledged that they were unsure if the mechanical lift had been disinfected before it was brought to them by CNA #1. They both confirmed they did not use the sanitizing wipes provided by the facility and that the purpose of cleaning the mechanical lift between resident use was to prevent the spread of infection. An interview on 3/21/23 at 2:35 PM, with the Registered Nurse (RN)/ Infection Control Nurse confirmed that staff should clean the shared equipment, which included the mechanical lifts, with sanitizing wipes between resident use to prevent the spread of infection.	F 880	supervisory staff over resident care staff will complete the following modules of the Nursing Home Infection Preventionist Training on the CDC website at https://www.train.org/cdctrain/training-plan /3814. Module 11A Reprocessing Reusable Resident Care Equipment. This training will be completed by 04/20/2023. Agency staff that are direct patient care will be required to complete Module 11A. 4 The audit findings will be reviewed by the Infection Prevention Nurse with the Quality Assurance committee monthly for three months to ensure continued compliance beginning May 4, 2023. A Infection Prevention Nurse will do a Weekly/Monthly Multi-Use Equipment Audit beginning on 04/12/2023 for 4 weeks and then monthly for 3 additional months on each area of the building to ensure lifts are being cleaned properly between each use. (see Weekly/Monthly Multi-Use Equipment Audit)	