STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011054	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTWOOD HOMES SENIOR LIVING INC III	1407 N MASON STREET APPLETON, WI 54914

(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
N 000	Initial Comments On 10/27/2025 and 10/28/2025, with additional information gathered through 11/04/2025, Surveyors conducted a standard survey, facility self-report review and complaint investigation at Heartwood Homes Senior Living III. As a result one deficiency was identified. The complaint was unsubstantiated. Census: 14	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and staff interviews, the provider did not have evidence Resident 1 was assessed at admission, annually or when there was a change in the resident's physical and mental condition for the potential risks associated with bed rail use. Resident 1 had a bed rail assist bar since admission, was cognitively impaired, and assessed to be at high risk for falls. Resident 1	N 381		

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

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N 381	Continued From page 1 fell a total of four times from 11/26/2024 through 12/06/2024, three of the four falls were from bed. On or around 12/06/2024, Resident 1 experienced a change in physical and mental condition and there were no changes to Resident 1's ISP (Individual Service Plan) or updated assessment to determine if new interventions were needed to reduce the risk of injury. On 01/06/2025, Resident 1 was found by staff lying in a prone position, horizontally next to his/her bed on the floor, with Resident 1's head towards the top of the bed. Resident 1's neck was resting on the horizontal bar of the bed assist bar. The facility did not comprehensively assess for the potential risks associated with the bed rail use, attempt alternative interventions before implementing the assist bar or re-assess when there was a change in condition. Resident 1's ISP did not include the use of the bed assist bar, the identified need, education provided to the resident/legal representative about possible hazards or alternative options for reducing the risks. In addition, there was no system in place to monitor and routinely inspect bed rail devices. Findings include: According to https://www.fda.gov/medical-devices/hospital-beds/guide-bed-safety-bed-rails-hospitals-nursing-homes-and-home-health-care-facts, revised April 2010 indicated, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe...Potential risks of bed rails may include:	N 381		

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N 381	Continued From page 2 Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress, more serious injuries from falls when patients climb over rails, skin bruising, cuts, and scrapes, inducing agitated behavior when bed rails are used as a restraint, feeling isolated or unnecessarily restricted, preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. Most patients can be in bed safely without bed rails. Consider the following: Use beds that can be raised and lowered close to the floor to accommodate both patient and health care worker needs. Keep the bed in the lowest position with wheels locked. When the patient is at risk of falling out of bed, place mats next to the bed, as long as this does not create a greater risk of accident. Use transfer or mobility aids. Monitor patients frequently. Anticipate the reasons patients get out of bed such as hunger, thirst, going to the bathroom, restlessness and pain; meet these needs by offering food and fluids, scheduling ample toileting, and providing calming interventions and pain relief. When bed rails are used, perform an on-going assessment of the patient's physical and mental status; closely monitor high-risk patients..." According to https://www.fda.gov/media/88765/download dated April 2003 and titled, "Clinical Guidance for the Assessment and Implementation of Bed rails in Hospitals, Long term Care settings and Home Care setting" ...1. The automatic use of bed rails may pose unwarranted hazards to patient safety. When planning patient care the following should be considered: The potential for serious injury is more likely to be related to a fall from a bed with	N 381		

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N 381	Continued From page 3 raised bed rails when the patient attempts to climb over, around, between, or through the rails, or over the foot board, than from a bed without rails in use. Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. Bed rails sometimes restrain patients...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses. 2. Decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian. 3. The patient's right to participate in care planning and make choices should be balanced with caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable state and federal laws and regulations. Policy Considerations: 1. Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment. 2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team. 3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team. Bed rail effectiveness should be reviewed on a regular basis. The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if	N 381		

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they were previously attempted and determined not to be the treatment of choice for the patient. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan. The care plan should: Include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use...Assessment of risk should be part of the individual patient's assessment, and steps to address the risk should be incorporated into the patient's care plan...If it is determined that bed rails are required and that other environmental or treatment considerations may not meet the individual patient's assessed needs, or have been tried and were unsuccessful in meeting the patient's assessed needs, then close attention must be given to the design of the rails and the relationship between rails and other parts of the bed...9. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items should be ongoing..."

On 01/08/2025, the Department received a facility self-report written by Administrator A, which indicated, "GOOD FAITH REPORTING- Resident death 'Possibly' related to an accident or injury...On 01/06/2025, at 8:30 AM, staff smelled a strong BM odor in the west hallway, as it wasn't present shortly beforehand. The three staff started to check the rooms to see where the smell was coming from. [Caregiver C] entered [Resident 1's] room at 8:30 AM and found [him/her] lying in a prone position, horizontally, next to [his/her] bed on the floor, with [his/her] head towards the top of the bed. [His/her] legs were straight, and both arms were straight

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alongside [his/her] body. [His/her] neck was turned to the right as if [s/he] was looking away from the bed. [His/her] neck was resting on the horizontal bar of the bed assist bar. [Caregiver C] tried to wake [Resident 1] by saying [his/her] name and shaking [him/her]. There was no response. [Caregiver C] then yelled for [Caregiver E]. They both tried to lift [him/her] off the bar but couldn't. [Caregiver C] determined [Resident 1] was not breathing and had no pulse. [Caregiver C] instructed another staff member [Caregiver D] to call 911, which [s/he] did. One of the staff from the adjacent building was called to help get [Resident 1] off the bed cane bar. With the three of them, they were able to lift [Resident 1's] upper body and head off the bar and lower [him/her] to the ground. Since [s/he] was not breathing with no pulse, they did not perform CPR as [s/he] is registered as a no-code. [Caregiver C] suspected [Resident 1] fell very recently as [his/her] body was warm and had drool coming from [his/her] mouth. [Caregiver C] informed me [Resident 1] always gets [him/herself] up in the morning, gets [him/herself] in and out of bed, and uses the bed assist bar. [Caregiver C] stated when [Resident 1] woke up, [s/he] would toilet self and, half the time, change [his/her] clothing without assistance, depending on the day. [Caregiver E] also confirmed this. EMTs, police, and fire department personnel arrived. EMT's assessed and determined [Resident 1] had passed away and did not perform CPR. They told [Caregiver C] it must have occurred recently as [his/her] body was still warm. Staff left the room for the officials to take over. [Caregiver C] saw that the police took pictures. Sometime later, police called [Caregiver C] back into the room and interviewed [him/her]. No other staff members were interviewed. The coroner and funeral home arrived shortly later, along with

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N 381	Continued From page 6 [Resident 1's] family. [Resident 1's] body was released to the funeral home...EMTs and the coroner did not state a cause of death at the time. The coroner did not comment on the cause of death, heart attack, or fall. Upon my investigation, [Caregiver C] stated there was plenty of room between the vertical bar assist and the mattress. About 2-3 inches on both sides of [Resident 1's] head. [Caregiver C] stated that if [Resident 1] was conscious, [s/he] could easily lift [his/her] head out, and it was not entrapped. Staff member [Caregiver D] was interviewed. [Caregiver D] confirms [Caregiver C's] story that they all smelt an odor of BM from one of the rooms. They all started checking the rooms in the west hall. [Caregiver C] found [Resident 1]. [Caregiver D] entered the room and saw [Caregiver C] was checking to see if [Resident 1] was breathing. [Caregiver C] said [Caregiver E] then tried to move [Resident 1's] head off the bar, but they were unsuccessful. [Caregiver C] instructed [Caregiver D] to call 911. [Caregiver D] stated [Resident 1] was lying on [his/her] stomach, with both arms to the side and legs straight. [Caregiver D] was unsure of the exact position of the head and neck but believed it was turned away from the bed. [Caregiver D] stated [Resident 1] gets [him/herself] up in the morning and then comes out of [his/her] room...[Caregiver E] was also interviewed. [Caregiver E] mirrored the other two staff descriptions, saying they all smelled BM in the west hall, and began searching rooms to see where it was coming from. [Caregiver C] started screaming [his/her] name to come help. They both tried lifting [Resident 1] off from the horizontal bed assist bar but couldn't budge [him/her]. [Caregiver C] instructed [Caregiver D] to call 911. [Caregiver E] stated [Resident 1] was found lying stomach down, both arms at the side, and [his/her] neck was on the	N 381		

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bar. [Caregiver E] was shocked and panicking but believed [his/her] head was turned away from the bed, but [Caregiver E] was not exactly sure. When asked, [Caregiver E] stated there was enough space on both sides of [Resident 1's] head to lift [his/her] head out easily without being trapped. [Caregiver E] guessed at least 3 inches of space on both sides of [Resident 1's] head between the mattress and the vertical assist bar ...All five staff interviewed confirmed [Resident 1] uses the nurse call light appropriately when [s/he] needs help with any care or task. The Guardian purchased and provided the bed-assist rail when [Resident 1] was admitted to the facility..."

A police report dated 01/06/2025 at 8:42 AM indicated, "On 01/06/25, Officer was led to [Resident 1's] room where AFD (Appleton Fire Department) and GCA (Gold Cross Ambulance) were present. Despite obvious lividity present in [Resident 1], AFD and GCA wanted to apply cardiac monitoring equipment as [Resident 1] was warm to the touch. No rigor was present at the time. No heart activity was noted...Staff had provided the resident information to AFD, who provided it to Officer. It identified the patient as [Resident 1], and included a copy of the DNR (Do Not Resuscitate) order...[Caregiver C] had found [Resident 1], and told me [Resident 1] was usually the first resident awake in the morning. When [Resident 1] hadn't gotten up yet, [s/he] went to check on [Resident 1], finding [him/her] down in [his/her] room shortly before the 911... [Caregiver C] stated [s/he] found [Resident 1] out of [his/her] bed, laying face down on [his/her] pillow, draped over the grab-bar adjacent to [his/her] bed. There appeared to be bodily fluid of some kind on the pillowcase and corner of the mattress closest to the pillow. [Caregiver C] had pulled [Resident 1] off the grab bar with the help

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of other staff, but did not attempt any life saving measures. [Caregiver C] advised [Resident 1] received dialysis 3 times per week...[Coroner G] responded took over scene. As there were no signs of criminal activity and no further death investigation, Officer left the scene..." On 10/29/2025 at 2:50 PM, Surveyor interviewed Coroner G regarding the 01/06/2025 incident involving Resident 1. Coroner G indicated s/he signed Resident 1's death certificate on 01/17/2025 as "Natural due to probable myocardial infarction and hypertension complications."

On 10/28/2025, Surveyors reviewed Resident 1's closed record. The record indicated Resident 1 was admitted to the facility on 09/20/2022 with diagnosis to include, intellectual disability, dementia, Parkinson's, chronic kidney disease with heart failure, diabetes and depression. Resident 1 had a guardian and advanced directives which indicated, "Do Not Resuscitate." Resident 1 passed away at the facility on 01/06/2025.

Resident 1's most recent ISP dated 10/19/2024 indicated, "[Resident 1] ambulates with a wheelchair; doesn't always pick up feet and will let shoes/slippers skid across the ground. [Resident 1] can ambulate with the use of a walker, however prefers the wheelchair. [Resident 1] can transfer independently. When sitting in a chair uses the arms for support to stand...[Resident 1] needs reminders and stand by assist to be able to pick out clothing and dress self independently. [Resident 1] is able to toilet self independently, is incontinent of bladder and sometimes bowel. [Resident 1] is able to position and align body independently. [Resident 1] is independently with eating, typically eats 100

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percent of meals, will often ask for snacks throughout the day...[Resident 1] is at high risk for falls, has a history of falls due to unsteady gait and becomes shaky especially after dialysis. Receives dialysis three times per week..."

**Resident 1's most recent ISP did not include the use of the bed assist bar, the identified need of the bar, education provided to the resident/legal representative about possible hazards or alternative options for reducing the risks of the bar use. Surveyor reviewed all previous ISP's for Resident 1 dated 10/19/2022 and 10/19/2023, both ISP's did not indicate the use or need of the bed rail device, education provided or alternative options for reducing risks.

**No risk-benefit assessment or physician's order for the bed assist bar could be located within Resident 1's medical record.

Fall Report forms for Resident 1 were reviewed from 11/26/2024 through 01/06/2025. The fall report forms indicated Resident 1 fell from bed on 11/26/2024 and twice on 12/04/2024 and revealed the following:

*11/26/2024- Middle of night Fall: Unwitnessed. Resident found: "Resident came out and told staff." Contributing factors: "Resident fell from bed, not wearing proper footwear, slippery floor." What was the resident trying to do: "Stand/transfer without help." ...Injuries: "Bruises to both knees."

*12/04/2024- 1:05 AM Fall: Unwitnessed. Resident found: "On floor in room." Contributing factors: "Resident fell from bed." What was the resident trying to do: "Going to the bathroom, Stand/transfer without help" ...Injuries: "Left and

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N 381	Continued From page 10 right knee has bump and bruise." *12/04/2024- 9 AM Fall: Unwitnessed. Resident found: "On floor in room." Contributing factors: "Resident fell from bed, lost balance while walking, not wearing proper footwear, poor lighting, weakness, increased confusion." What was resident trying to do: "Stand/transfer without help." ...Injuries: "Bump or Bruise on both knees." *12/06/2024- 2 AM Fall: Unwitnessed. Resident found: "On floor in room." Contributing factors: "Resident tripped, lost balance while walking, not wearing proper footwear, slippery floor." What was resident trying to do: "Stand/transfer without help." ...Injuries: "...Right knee abrasion..." A physician home visit note for Resident 1 dated 12/06/2024 indicated, "Chief Complaint: 3 falls this week...[Resident 1] with a history of multiple chronic conditions including end-stage renal disease, dementia, heart failure, and type 2 diabetes, is seen today for evaluation following three falls this week. Staff reports [s/he] had two falls on 12/4 and one on 12/6, with increasing difficulty getting [him/her] up from the floor. [Resident 1] relates feeling tired, rundown, and not eating or drinking much. [Resident 1] states [s/he] was using [his/her] walker when trying to transfer. [Resident 1] continues [his/her] dialysis schedule three times a week on Monday, Wednesday, and Saturday. Staff reports [Resident 1] is eating only 25 to 50% of [his/her] meals and has been falling asleep in [his/her] wheelchair. [S/he] has been incontinent of bowel and bladder for the last 3 days, which is a new development ....The current presentation of multiple falls, increased lethargy, and new incontinence represents a significant decline from	N 381		

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N 381	Continued From page 11 his previous condition... An ED (Emergency Department) "After Visit Summary" for Resident 1 dated 12/23/2024 indicated, "Reason for Visit: Altered Mental Status. Diagnosis: Weakness..." **Surveyors did not locate within Resident 1's medical record any additional ISPs or ISP revisions after 10/19/2024. Resident 1's ISP dated 10/19/2024, which was signed and acknowledged by Resident 1's legal representative and Assistant Administrator B did not include any revisions or address additional interventions to reduce the potential for injury when Resident 1 experienced falls and a change in condition. On 10/28/2025 at 11:20 AM, Assistant Administrator B verified the most recent ISP for Resident 1 was 10/19/2024 and there were no other ISPs or changes made after 10/19/2024. INTERVIEWS On 10/28/2025 at 9:30 AM, Surveyor interviewed Caregiver C regarding Resident 1. Caregiver C indicated Resident 1 was receiving dialysis three times a week, utilized a wheelchair and walker and required assistance with dressing because "[Resident 1] would not change [his/her] cloths." Caregiver C stated, "About two months prior to the 01/06/2025 incident, [Resident 1] was weaker and out of it. [Resident 1] would come back from dialysis and would just want to sleep...[Resident 1] was pretty weak towards the end, [s/he] stayed in [his/her] wheelchair and needed help with transfers...When [Resident 1] used the bathroom [s/he] would hold onto the grab bar, and I would assist [him/her] with a pivot transfer to the toilet... [Resident 1] would nap a lot more than normal	N 381		

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	0011054	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTWOOD HOMES SENIOR LIVING INC III	1407 N MASON STREET APPLETON, WI 54914

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and lost [his/her] appetite." Surveyor then questioned Caregiver C about the above facility self-report. Caregiver C confirmed Resident 1 had a bed assist bar since admission and thought Resident 1's bed assist bar was for transferring into or out of bed. Surveyor asked Caregiver C to explain Resident 1's bed assist bar. Caregiver C indicated Resident 1's bed assist bar was positioned between his/her box spring and mattress, with a strap that went around the bed frame and clipped to hold the bar in place. Caregiver C stated, "On 01/06/2025, I walked into [Resident 1's] bedroom and seen [Resident 1] lying on the ground next to [his/her] bed on [his/her] stomach, with [his/her] head turned towards the wall and [his/her] neck resting on the base frame bar (the bar that goes in-between the mattress and box spring). The bed assist bar was pushed away from the box spring and mattress and [Resident 1's] neck was resting on the base frame bar...There was about two or three inches of the base frame bar exposed on both sides of [Resident 1's] head...I called for [Caregiver D and E] to come help...[Caregiver D] called 911, while [Caregiver E] and another caregiver from the sister building helped me lift [Resident 1] off the base frame bar...I don't know if [Resident 1] was trying to get out of bed and fell, if [s/he] passed out and fell, or had heart issues...[Resident 1's] head was not stuck... [Resident 1] was weaker the last few months." Surveyor asked if [Resident 1's] call light was activated when s/he found Resident 1. Caregiver C stated, "No it wasn't...[Resident 1] didn't really use the call light." Surveyor asked Caregiver C if s/he wrote a statement or documented the 01/06/2025 incident with Resident 1. Caregiver C stated, "I didn't document the incident...I was questioned by [Administrator A], [Assistant Administrator B] and the police, but I don't recall

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writing a statement or documenting it." Surveyor asked Caregiver C if s/he was directed to monitor and document Resident 1's bed assist bar to ensure the safety strap was in place, the bar was tight against the mattress and functioning properly. Caregiver C verified s/he was not directed to routinely monitor or document inspections of Resident 1's bed assist bar. Caregiver C stated, "I did fix [Resident 1's] bed assist bar one time when it was loose." Surveyor questioned if the information was reported to management. Caregiver C stated, "No, I should have."

On 10/28/2025 at 10:20 AM, Surveyor interviewed Caregiver D regarding Resident 1. Caregiver D indicated s/he primarily works the AM shift and stated, "[Resident 1] was full care...I would help get [him/her] up most of the time... [Resident 1] did have falls that were occurring more often the last few months before [s/he] passed away...During the last few months [Resident 1] was very tired and weak...Sometimes [Resident 1] would self-transfer out of bed, but I would discourage it because I didn't want [him/her] to fall...[Resident 1] was mainly in the wheelchair...I would take [Resident 1] to the bathroom when [s/he] had to go and have [him/her] hold onto the grab bar in the bathroom, and then assist [him/her] with a pivot transfer." Surveyor asked Caregiver D about the above facility self-report. Caregiver D stated, "On 01/06/2025, [Caregiver C] yelled for help and said [s/he] thinks [Resident 1] fell. When I walked into the room [Resident 1] was on the floor next to [his/her] bed on [his/her] stomach. I could see [Resident 1's] neck was resting on the lower bar of the bed assist bar, the lower bar that's supposed to be inbetween the mattress and box spring...The bed assist bar was

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out and not secure...I left the room right away and called 911." Surveyor asked Caregiver D if s/he wrote a statement or documented the 01/06/2025 incident with Resident 1. Caregiver D stated, "I didn't document what I saw or the incident. I was asked questions over the phone by [Administrator A] about what I saw." Surveyor asked Caregiver D about the bed assist bar. Caregiver D indicated, Resident 1 had the bed assist bar since s/he started working in the facility. Caregiver D stated, "[Resident 1's] bed assist bar had a bar that went in-between the mattress and box spring and was strapped or clipped into place around the bed frame. I believe the purpose of the bar was for [Resident 1] to sit up in bed...I never saw [Resident 1] use it. I would give [Resident 1] my hands to help [him/her] sit up in bed and transfer [him/her] out of bed without the bar." Surveyor then asked about the facility's process for monitoring and inspecting bed rails. Caregiver D indicated there was no specific system for monitoring or inspecting bed rails regularly.

On 10/28/2025 at 11 AM, Surveyor interviewed Caregiver F regarding Resident 1. Caregiver F stated, "[Resident 1] was declining the last few months...[Resident 1] was not eating and drinking as much, and had some falls. When [Resident 1] would return from dialysis [s/he] was more confused. [Resident 1] was mainly in a wheelchair, and I would assist [him/her] with transfers in and out of bed with a gait belt. [Resident 1] would sometimes use the bed assist bar, but when I got [him/her] out of bed [s/he] would use the wheelchair arm rest." Surveyor then asked about the bed assist bar. Caregiver F stated, "[Resident 1] has had a bed assist bar since I started working here...I believe the purpose of the bar was to help [him/her] get up out of bed. The bar was connected to something

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N 381	Continued From page 15 underneath the bed or in the bed, but I'm not sure." Surveyor asked Caregiver F if s/he was directed to monitor and document Resident 1's bed assist bar to ensure the safety strap was in place, the bar was tight against the mattress and functioning properly. Caregiver F verified s/he was not directed to routinely monitor or document inspections of Resident 1's bed assist bar. On 10/28/2025 at 2:30 PM, Surveyors interviewed Administrator A and Assistant Administrator B regarding the above facility self-report. Surveyors asked if they had any additional information regarding the above facility self-report. Administrator A and Assistant Administrator B verified the above facility self-report documentation was what they had. Surveyors ask if the facility had a policy and procedure for the assessment and implementation of bed rails. Administrator A stated, "No." Surveyors then asked if a bed rail assessment was completed for Resident 1. Administrator A stated, "When a resident comes in with a bed rail we do an assessment...[Resident 1] used it at home and it would be in the chart." Surveyors indicated there was no bed rail assessment located within Resident 1's closed medical record. Administrator A indicated s/he completed an assessment of Resident 1's bed rail but didn't document it. Surveyors indicated Resident 1's ISP did not include the use of the bed assist bar, the identified need of the bar, education provided to the resident/legal representative about possible risks or alternative options for reducing the risks associated with the use. Administrator A stated, "We typically put it in the care plan." Surveyors asked Administrator A about Resident 1's bed assist bar. Administrator A indicated the bed assist bar was a Medline Assist Bar (MDS6800BAHWI) that had floor stabilizers and a	N 381		

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N 381	Continued From page 16 belt with a buckle attached. Administrator A stated, "After the 01/06/2025 incident, we were assessing [Resident 1's] grab bar and one end of the buckle was broken, which could've happened when [Resident 1] fell onto the grab bar and pushed it away from the bed mattress, [s/he] was a bigger person." Surveyors then asked about the facility's process for monitoring and inspecting bed rails. Administrator A indicated there was no specific documentation for monitoring or inspecting bed rails regularly and stated, "Resident beds are made daily, we inspect then, and if a bed rail is jiggly or loose, I would expect staff to tell us." Surveyors then asked what actions or steps were taken following the 01/06/2025 incident. Administrator A stated, "We went around and checked all the bed assist bars to make sure they were all working and safe..." Surveyors questioned if any staff education was completed following the 01/06/2025 incident. Administrator A stated, "I believe we had done some education in January 2025, a staff communication note was placed in a binder that staff initial...If education was done it would be in the binder." Surveyors requested to see the education provided to staff. At 3:28 PM, Administrator A indicated s/he could not find any staff education following the 01/06/2025 incident.	N 381		