STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA ESTATES SKILLED CARE	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		9/13/18

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

Electronically Signed | 09/10/2018

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F 582	Continued From page 1 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the Notice of Medicare Non Coverage (NOMNC) Form Centers of Medicare (CMS) 10123 prior to discharge from Medicare Part A Services for 2 of 3 residents reviewed (Residents #26 and #61). Findings included: Resident #26 was admitted to the facility on 2/2/2018 with diagnoses that included Diabetes Mellitus, End Stage Renal Disease (ESRD), chest pain, chronic pain and hypertension. Review of records revealed Resident #26 Medicare Part A Services began on 2/25/2018 and terminated on 4/15/2018. Resident #26 was discharged from Medicare Part A Services with benefit days remaining. The NOMNC Form CMS 10123 was not provided to Resident # 26 by the facility. Resident # 61 was admitted to the facility on 5/25/2018 with diagnoses that included chronic kidney disease, obstructive sleep apnea, history of cerebrovascular accident and hypertension. Review of records revealed Resident #61 Medicare Part A Services began on 5/25/2018 and terminated on 6/13/2018. Resident #61 was	F 582	As evidence by the facility failed to provide the Notice of Medicare Non Coverage (NOMNC) Form Centers of Medicare (CMS) 10123 prior to discharge from Medicare Part A services for Resident #26 and #61. The Notice of Medicare Non Coverage (NOMNC) form Centers of Medicare (CMS) 10123 was issued for Resident #26 on 8/16/18 and for Resident #61 on 9/10/18. Other residents identified to require a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) and Notice of Medicare Non Coverage (NOMNC) were provided to the resident and/or responsible party prior to discharge from Medicare Part A Services by the Business Office Manager (B.O.M.) There was one resident identified and the (NOMNC) and (SNFABN) was issued on 9/4/18.	

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F 582	Continued From page 2 discharged home from Medicare Part A Services with benefit days remaining. The NOMNC Form CMS 10123 was not provided to Resident # 61 by the facility. During an interview on 8/16/2018 at 3:39 PM the Business Office Manager (BOM) revealed she was not aware of specifications on when to provide Form CMS 10123. The BOM further revealed if she provided the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) Form CMS 10055 then the NOMNC Form CMS 10123 was not necessary for residents discharged from Medicare Part A Services. During an interview on 8/16/2018 at 3:51 PM the Administrator revealed that she expected all residents with benefit days remaining to receive Forms CMS 10055 and 10123 when discharged from Medicare Part A Services.	F 582	An in-service was provided by the Administrator on 9/10/18 for the Business Office Manager and the Interdisciplinary team to ensure the understanding and requirements of the (NOMNC) and (SNFABN). A weekly Medicare meeting will be held to monitor Medicare Part A skilled coverage and upcoming required notices. The Administrator and/or the Assessment nurse will facilitate the meeting. The NOMNC and SNFABN notices will be audited monthly by the Administrator for three months and quarterly thereafter and findings reviewed by the Quality Assurance Committee for continued quality improvement.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		9/13/18

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F 584	Continued From page 3 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to provide an odor free environment for one of three halls, the 200 Hall, and failed to provide clean curtains in 1 of 4 rooms reviewed for environment, room 205. Findings included: An observation of room 205 was conducted on 8/15/18 at 4:23 PM at room 205. Prior to entering room 205 there was a detectable urine/ammonia odor while standing at the doorway. Upon entering room 205 the urine/ammonia odor was	F 584	As evidence by the facility failed to provide an odor free environment for one of three halls, the 200 hall, and failed to provide clean curtains in one of four rooms reviewed for environment, room 205. Room 205 had the privacy curtain changed on 8/16/18. The room was deep cleaned on 8/21/18. There is no urine odor detected. The floors were cleaned and has no sticky residue. In room 205 the mattress and bed frame	

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F 584	Continued From page 4	F 584		

more pungent and increased in intensity near the bed closest to the door. An observation of the privacy curtain for both the bed closest to the door and next to the window revealed multiple brown spots on each curtain when they were unfurled. There was no resident observed in the bed closest to the door and resident whose bed was next to the window was in the room. The floor near the bed by the door had a sticky residue around the bed.

An observation of room 205 was conducted on 8/16/18 at 2:48 PM at room 205. Prior to entering room 205 there was a detectable urine/ammonia odor while standing at the doorway. Upon entering room 205 the urine/ammonia odor was more pungent and increased in intensity near the bed closest to the door. An observation of the privacy curtain for both the bed closest to the door and next to the window revealed multiple brown spots on each curtain when they were unfurled. Neither the resident at the door nor the resident at the window were present during the time of the observation.

An observation of room 205 and interview was conducted on 8/16/18 at 2:50 PM with the Nursing Assistant (NA) #1 who had been assigned to room 205. The NA stated there was a strong odor of urine in the room at the time of the observation. The NA stated there usually was an odor of urine in the room, but it was not usually as strong as it was during the time of the observation. The NA stated both residents in the room were incontinent of urine. The NA stated she had provided incontinence care for the resident who was near the door about 15 minutes prior to the observation. The NA stated the resident in the bed near the door would remove

were wiped, the room dusted, swept and mopped. The blinds, bedside table and over bed table were cleaned.

all 38 rooms were inspected on 8/22/18 and room 208 was identified by the Maintenance Director to need a deep cleaning to ensure a safe, clean, comfortable and homelike environment. Room 208 was deep cleaned on 8/22/18. This included changing the privacy curtain, wiping the mattress and bedframe, sweep, mop, dust and cleaning the blinds, bedside table and over bed table.

An in-service was provided for housekeeping, maintenance and nursing staff on 9/10/18 by the Maintenance Director and Director of Nurses on the expectation for a clean, safe, comfortable and homelike environment. To include communication via work orders from the clinical team to housekeeping when cleaning needs arise in a resident room on a daily basis.

For continued quality improvement a deep cleaning schedule has been developed to ensure one room per hall (100 hall, 200 hall and 300 hall) per week (3 rooms per week)beginning 8/22/18. All 38 rooms will be deep cleaned quarterly to meet the expectations of a clean and odor free environment. The room inspection form will be completed by the maintenance director and/or administrator weekly beginning 8/22/18 and findings reviewed

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F 584	Continued From page 5 her soiled brief and place it in a bag an leave it on the floor and the staff would pick it up later. The NA stated the odor of urine was more intense near the bed closest to the door. The NA stated there were spots on the curtains but was not aware of the spots or where the spots had come from. An observation of room 205 and interview was conducted on 8/16/18 at 3:57 PM with the Maintenance Director (MD). The MD stated in addition to supervising maintenance he also oversaw the Housekeeping Department. The MD stated there was a urine odor in room 205. The MD stated he had air fresheners which could be placed in the Packaged Terminal Air Conditioner (PTAC) units. The MD stated there had not been an air freshener placed in the PTAC in room 205. The MD observed the spots on the curtains in room 205 and stated the curtains needed to be changed. The MD stated the curtains were taken down and replaced with fresh curtains when the rooms were deep cleaned. The MD stated the curtains which were removed would be laundered. In addition, during the MD stated during deep cleaning the mattresses would be cleaned, the bed frames would have been wiped down, and the rest of the room thoroughly cleaned during a deep clean. The MD stated each resident room was deep cleaned quarterly. A request was made to the MD to provide the deep cleaning schedule and a list of the rooms which had been cleaned during the previous quarter. An interview and record review were conducted with the MD on 8/16/18 at 4:26 PM. The MD stated he was unable to provide a deep cleaning schedule for the resident rooms of the facility	F 584	in the Quality Assurance Committee monthly for three months and quarterly thereafter to ensure continued quality improvement.	

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F 584	Continued From page 6	F 584		

which had been completed or were schedule to be completed. The MD provided a checklist which has been most recently completed on 5/28/18 for the 200 Hall. The checklist had each resident room and other rooms on each hall. The tasks listed on the checklist included dust, sweep, mop, trash, toilet paper, paper towels, hand soap, blinds, bed, bedside table, overbed table, deep cleaning. All tasks were marked indicating completion for the 200 hall resident rooms except for blinds, bed, and deep cleaning. Further review of the checklists provided revealed room 205 had not checked indicating deep cleaning had been completed back to and including 2/21/18. A Housekeeping Checklist (Nursing) was provided for the 100, 200, and 300 Halls. The Checklist was conducted by the Administrator on 5/16/18 for the 200 Hall. Room 205 was documented as having been unsatisfactory for Doors and Frames, Overbed Table, Ceiling/Walls (Bathroom), Heat Air Conditioner Unit, and Fan in Bathroom. On the reverse side of the Checklist the Administrator had made the following comments regarding room 205; drawer missing, dust in vent, bathroom ceiling tile stained, dust in light bulbs, and paint door casing. The checklist included no Inspection Element regarding odors detected in the rooms inspected. The MD stated another Housekeeping checklist had been scheduled to have been completed the week of 8/13/18 but the arrival of the survey team did not allow it to be completed.

An interview was conducted with the Administrator on 8/16/18 at 4:48 PM. The Administrator stated the housekeeping department cleaned the resident rooms thoroughly. The Administrator stated if there was

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F 584	Continued From page 7 a urine odor in a resident room there were chemicals the housekeeping department could use to address the odor promptly. The Administrator stated the MD went into detail with the Hall Checklists and she went into detail with Housekeeping Checklist, but they had not completed either since May. The Administrator stated there was not a deep cleaning schedule and as room odors are identified they will deep clean a room, there was no deep cleaning schedule. The Administrator stated it was her expectation for rooms to not smell of urine.	F 584		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than	F 642		9/13/18

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F 642	Continued From page 8 $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the comprehensive minimum data set (MDS) assessment was complete before submitting the assessment for 1 of 3 residents reviewed (Resident # 54). Resident # 54 was admitted to the facility on 4/4/2016 with diagnoses that included vascular dementia, cerebrovascular accident with hemiplegia/paresis (paralysis/weakness affecting one side) and chronic lung disease. The comprehensive MDS dated 3/8/2018 indicated Resident #54 was severely cognitively impaired. Section F of the assessment contained questions about Resident #54's Preferences for Customary Routine and Activities. None of the questions were answered. During an interview on 8/15/2018 at 3:59 PM, the MDS Coordinator revealed she did not sign the comprehensive MDS in question despite acknowledgment of her signature dated 3/21/2018. The MDS Coordinator further revealed that she is a licensed practical nurse and only a registered nurse could sign the assessment for completion. The MDS Coordinator indicated her signature indicated the assessment was complete. During an interview on 8/16/3018 at 4:50 PM, the	F 642	As evidence by the facility failed to ensure the comprehensive minimum data set (MDS) assessment was complete before submitting the assessment for 1 of 3 residents reviewed (resident #54) Resident #54 Minimum Data Set (MDS) Assessment was corrected and signed by the Registered Nurse and Section F (Activities) was reviewed with the Activities Director on 8/15/18. All other MDS assessments when completed daily or weekly will be checked by the Director of Nurses and/or Administrator to ensure MDS's are accurate and signed prior to submitting the assessment. An in-service is scheduled for 9/13/18 for all disciplines who complete portions of the MDS assessment to sign and certify the accuracy of that portion of the assessment. As MDS's are scheduled and completed by all disciplines, the Director of Nurses and/or Administrator will audit the MDS for accuracy and for the Registered Nurse signature of completion. Findings will be reviewed at the Quality Assurance Committee monthly for three months and quarterly thereafter for continued quality improvement.	

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F 642	Continued From page 9 Administrator revealed she expected section F of the assessment to be completed and the registered nurse assessment coordinator to submit complete MDS assessments.	F 642		
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 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, staff interviews, and record review the facility failed to assess for the need and remove unnecessary side rails from a bed for 1 of 2 residents reviewed for accidents (Resident #18). Findings included:	F 700	As evidence by the facility failed to assess for the need and remove unnecessary bedrails from a bed for 1 of 2 residents reviewed, resident #18. Resident #18 was assessed and the bedrail assessment was updated by the	9/13/18

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F 700	Continued From page 10 Resident #18 was admitted to the facility on 5/23/18. The resident's diagnoses included: Dementia, Type II Diabetes, generalized weakness, restlessness and agitation, and lack of coordination. Review of Resident #18's most recent Minimum Data Set (MDS) Assessment revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 5/30/18. Review of the assessment revealed the resident was coded as having had severe cognitive loss. The resident was coded as having had required extensive or total assistance from one person or more for all Activities of Daily Living (ADLs) including: bed mobility, transfer (such as from the bed to a wheelchair), moving about the facility once in a wheelchair, dressing, eating, toilet use, personal hygiene, and bathing. The use of a bed rail was not coded as a restraint. Review of Resident #18's Device Decision Guide dated 5/23/18 revealed the resident was to have a right side one quarter rail for mobility. A review was completed of Resident #18's care plan, which was most recently updated on 6/8/18. Problem/Need areas on the resident's care plan included: The resident was mainly non-verbal, and she would stare blankly at times and not answer questions, she does not make her needs known. The resident had poor safety awareness related to dementia. The resident required staff assistance with ADLs. She was extensive to total care. She did not feed herself or propel her wheelchair. She was incontinent of bowel and bladder and required incontinence care. She transferred with a stand pivot and 1 assist. She is	F 700	Director of Nurses on 8/14/18. The bedrail was removed and the care plan was updated. On 8/27/18 all other residents identified with bedrails were assessed by the Director of Nurses and the bedrail assessment were updated and bed rails removed if indicated and appropriate alternatives attempted. The care plan was updated to indicate any changes made to the bed rails. The bedrail assessments will be reviewed quarterly and with any changes by the unit manager and/or Director of Nurses and changes reviewed in the weekly interdisciplinary team meeting. The changes will be noted on the bed rail assessment and the care plan updated with any changes. An in-service is scheduled for 9/13/18 by the Director of Nurses for the nursing staff on bedrails, bedrail assessments and bed positioning. The bedrail assessments will be reviewed monthly by the Director of Nurses for three months, then quarterly at the Quality Assurance committee for continued quality improvement. The Maintenance Director will check bedrails for functioning and securement on a quarterly basis and findings will be reported to the Quality Assurance Committee for continued quality improvement.	

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mainly non-verbal. An approach listed was the resident was to have a one quarter bedrail to the right side to aid in positioning and bed mobility. Discontinued the right bedrail: dated 8/14/18. The resident had a pressure ulcer to her sacrum and one of the approaches listed was to reposition the resident on routine rounds and as needed.

There was an update to the Device Decision Guide dated 8/10/18 for Resident #18 which stated one quarter siderail to right side continued to assist in mobility and positioning.

An observation of Resident #18 was conducted on 8/13/18 at 11:58 AM. The resident was resting in bed and the resident's family member was at the bedside. The resident was observed to be nonresponsive to questions. The resident's family member stated the resident could not wear clothes on and had to wear robes, and it was easier and better for her to stay in bed. The resident's family member displayed the resident's minimal flexion and contracture in both her right and left arms. The resident's family member stated the resident needed to be turned from right to left side in bed and have a wedge or pillow placed under the resident to keep weight off of the resident's bottom. The resident's bed was observed to have a quarter bedrail at the head of the bed on the resident's right side.

A review was completed Resident #18's Departmental Notes of a Nursing Services note dated 8/14/18 and timed 7:04 AM. The note documented the resident was reported by a family member to have had a red area to the right cheek and also a raised area in the middle of her forehead. The Nursing Assistant who had the

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resident during the 11:00 PM to 7:00 AM shift stated the resident had been lying on her right side and the resident's cheek was a little red. The nurse who had checked the resident's blood sugar prior to the husband's arrival on 8/14/18 stated the resident had not had any raised area to her forehead when she had checked the resident's blood sugar. The note was signed by Nurse #2.

A review of a Resident Incident Report for Resident #18 dated 8/14/18 and timed 7:04 AM was completed. The report was completed by the Director of Nursing (DON). The type of injury was listed as an abrasion. The location was listed as the resident's room. The narrative documented the injuries were reported by the resident's family. The resident had a red area to the right cheek and also a raised area in the middle of the forehead. The Nursing Assistant (NA) indicated she had seen the resident had been lying on that side earlier. The physician was notified. The immediate post-incident action was documented as: The resident continued to be repositioned during care rounds and as needed. The Interdepartmental Disciplinary Team (IDT) reviewed the incident. The IDT consisted of the Administrator, the DON, Physical Therapy (PT), Social Work, the Activities Director, the Dietary Manager, and the Unit Manager. The IDT determined the bedrail was removed and the bed control was changed to a hand-held bed control.

An observation of Resident #18 was conducted in conjunction with a family interview on 8/14/18 at approximately 5:00 PM. The resident's family member stated when he had come into the facility that morning before 7:00 AM he had observed the resident's face was reddened on the right cheek

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and the resident had a raised area to the forehead. An observation of the resident revealed the resident's right cheek was reddened and the there was a raised area to the resident's forehead. The raised area was observed to be slightly larger than a grape and had some blueish color to the raised area and around the raised area. Due to the resident's cognitive loss the resident was unable to provide information as to how the injury had occurred. The resident's family stated the resident had had a bedrail at the head of the bed on the right side and it had been removed. The resident's family stated the facility staff had informed him that it had been believed the resident's face had been against the bedrail and the bedrail had caused the injury.

A review was completed of the Resident #18's Departmental Notes of a Nursing Services note dated 8/15/18 and timed 5:12 AM. The note documented the resident's right cheek continued to be red but the reddened area was smaller in size than when the 11:00 PM to 7:00 PM shift had began. The note further documented there was no bruising noted to the right side of the face. The note was signed by Nurse #3.

A review was completed of Resident #18's Departmental Notes of a Nursing Services note dated 8/16/18 and timed 6:17 AM. The note documented the resident's right cheek remained red and had a small blister like area. The note further documented the resident denied pain or discomfort and had no acute distress noted. The note was signed by Nurse #3.

An observation of Resident #18 was conducted at approximately 3:35 PM. The resident was observed to be in her bed. The resident's bed

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was observed to not have had any bedrails. The raised bruise to the forehead was observed to have no longer been raised but a blue discoloration of the skin remained. The resident's right cheek remained reddened with some of the skin appearing to have been peeling off in a chapped type of manner.

An interview was conducted with the Unit Manager (UM) Nurse on 8/16/18 at 3:41 PM. The UM stated the issue of the Resident #18's reddened area on the right cheek and the bruise to the resident's forehead had been investigated. The UM stated the bruise to the resident's forehead and red mark to her face had been determined to have been caused by the bedrail which had been on the resident's bed and the bedrail had been removed. The UM stated the red mark and the bruise were not observed on the resident's face at 6:16 AM when the RN was doing a fingerstick for a blood sugar while the resident was resting in bed. The resident's NA was rounding after 6:16 AM and the NA observed the resident to be resting in bed lying on her right side and her face was on her right cheek. The NA also observed the resident's face and cheek were close to the bedrail. The resident's husband came to the facility at about 6:40 AM and observed the redness to the resident's right cheek and the bruise to her forehead.

An interview was conducted with the DON on 8/16/18 at 4:06 PM. The DON stated when she had arrived to the facility on 8/14/18 in the morning she had went to Resident #18's room to assess her. The DON stated the resident had a bedrail on her bed on the right side at the head of the bed. The DON stated the resident had been a resident at the facility prior to her admission

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date in May and when the resident was readmitted, the resident's family had asked for everything the resident had had prior to her discharge with readmission not anticipated which had occurred on 5/21/18. One of the items the resident's family had requested was the bedrail on her bed. The DON stated she had interviewed the NA who had the resident during night shift and she had went in to check the resident during her last round on her shift and the resident was laying on her right side with her face on the pillow and her face was close to the bedrail. The DON stated she had maintenance remove the bedrail. The bed control for the bed was part of the siderail and maintenance had installed a wired remote bed control in place of the bed control which had been part of the bedrail. The DON stated when she had assessed the resident at approximately 7:00 AM on 8/14/18 the resident's right cheek appeared slightly blistered and the resident had a bruised area to her forehead. The DON stated as a result of an investigation it was determined the resident's right cheek had been on the pillow and the injury to her forehead was from the bed control which was part of the siderail. The DON stated she had a bedrail assessment completed at the time of her readmission and the resident had been able to hold onto the right bedrail which aided in repositioning and care. The DON stated the resident's condition had declined since the bedrail assessment had been completed at the time of her admission. The DON stated the bedrail assessments were completed quarterly. The DON stated if it was determined a change needed to be made to a resident's bedrails from a bedrail assessment, the bedrail(s) would be changed to what was recommended on the assessment on the day of the assessment.

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An interview was conducted with the Administrator on 8/16/18 at 4:57 PM. The Administrator stated she was made aware of the Resident #18's injury when she had arrived to the facility on 8/14/18 at 7:40 AM. The Administrator stated it had been determined through the investigation the resident had been lying on the right side of the bed, on her right side, and the resident's forehead was resting on the center of the bedrail where the controls were for the bed. The Administrator stated the bedrail was removed on 8/14/18. The Administrator stated the resident's husband had initially discovered the injury and the resident had been found to be on her right side in the bed with her head against the bedrail. The Administrator also stated the resident's NA from the night shift had also observed the resident to have been lying on her right side and had a positioning wedge under her to position the resident on her right side and her head was against the bedrail. The Administrator stated the resident had only used the bedrail for positioning when she had first arrived to the facility. The Administrator stated bedrail assessments were completed quarterly. She stated there was an assessment completed by nursing for the resident's use of the bedrail and there was an assessment completed quarterly by maintenance for the function and safety of the bedrail. She stated when the resident had first arrived to the facility the resident had been able to use the bedrail and the bedrail remained on the resident's bed due to the bed controls having been located in the bedrail. The Administrator stated the bedrail had been removed and now the resident had a hand held bed control.