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	345384	A. BUILDING _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

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E 000	Initial Comments The survey team entered the facility on 8/5/24 to conduct a recertification and complaint investigation survey on 8/5/24 and were unable to return to the facility on 8/7/24 due to adverse weather of a tropical storm and unsafe travel conditions. Additional information was obtained remotely through 8/8/24. Therefore, the exit date was 8/8/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DP0411.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 8/5/24 to conduct a recertification and complaint investigation survey and were unable to return to the facility on 8/7/24 due to adverse weather of a tropical storm and unsafe travel conditions. Additional information was obtained remotely through 8/8/24. Therefore, the exit date was changed to 8/8/24. Event ID# DP0411. The following intakes were investigated NC00205390, NC00207159 and NC00219854. One (1) of the 6 complaint allegations resulted in deficiency.	F 000		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first	F 626		8/26/24

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

Electronically Signed | 08/23/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 626	Continued From page 1 availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, family, staff, Long Term Care Ombudsman, and hospital Emergency Department (ED) Case Manager interviews, the facility failed to allow a resident (Resident #23) to return to the facility to the first available bed after he was transferred to the hospital and cleared by a psychiatric evaluation to return to the facility on 7/25/23. The facility refused readmission, and the resident remained in the in the hospital Emergency Department until 7/27/23 when the State Agency and Long Term Care Ombudsman intervened. This was for 1 of 2 residents whose	F 626	Corrective Action for the Resident Affected On 07/27/2023, Resident #23 returned to the facility. Action for the Residents Potentially Affected On 08/19/2024, the Social Worker reviewed discharges of residents that were transferred to the hospital, and, or on therapeutic leave going back for the	

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F 626	Continued From page 2 discharge was reviewed. Findings included: Resident #23 was admitted to the facility on 11/4/22 with a diagnosis of dementia. A review of Resident #23's care plan revealed in part a focus area initiated on 4/17/23 related to Resident #23 experiencing agitation when he was brought out of his room. The goal was to avoid bringing Resident #23 out of his room. The intervention was that if Resident #23 needed to be brought out of his room for deep cleaning, to sit Resident #23 in his wheelchair outside his room door. A review of Resident #23's quarterly Minimum Data Set (MDS) assessment dated 5/12/23 revealed he was severely cognitively impaired. He exhibited physical behavioral symptoms directed towards others such as hitting and scratching, and verbal behavioral symptoms directed towards others such as screaming and cursing on 4-6 days of the look back period of the assessment. He exhibited physical behavioral symptoms not directed towards others on 4-6 days of the look back period. He rejected care on 1-3 days of the look back period of the assessment. Resident #23 required the maximal assistance of a helper to go from lying to sitting on the edge of the bed. He did not walk during the assessment period. A review of a nursing progress note for Resident #23 dated 7/25/23 at 3:12 PM written by Nurse #1 revealed the nurse was informed that Resident #23 was in a neighboring residents' room (Resident #33), which was connected to Resident #23's room by an adjoining bathroom. He was	F 626	past 30 days, beginning 07/18/2024 to 08/19/2024. Of the 15 residents transferred to the hospital, 14 returned to the facility when they were ready for readmission to the facility and 1 resident admitted to hospice services. The facility did not have any residents on therapeutic leave over the past 30 days. Systemic Changes On 08/19/24, the Regional Nurse Consultant in-serviced the Administrator on the facility's Bed Hold policy, which includes therapeutic leaves and transfers to the hospital. Administrator #2 is no longer with the company. On 08/20/24, the Administrator in-serviced the disciplinary team, Including the Director of Nursing, the Assistant Director of Nursing, the Social Worker/Admission Director, and the Business Office Manager on the facility□s Bed Hold Policy, which included therapeutic leave and transfers to the hospital. This policy will be reviewed with any newly hired employees in these roles. The Administrator and or Director of Nursing will randomly select 2 residents weekly times 4 weeks, 2 residents monthly, times 3 months, that have been transferred to the hospital and or has left the facility on therapeutic leave to ensure they were re-admitted per the facility□s bed hold policy, utilizing the Quality Assurance Monitoring Tool for Permitting	

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F 626	Continued From page 3 sitting on the end of her (Resident #33's) bed. When an attempt was made to redirect Resident #23 back to his room, Resident #23 became agitated, swung his arms at staff, grabbed the window blinds and began to bang the blinds against the window. Resident #23's family member was called in an effort to calm Resident #23 down, but this was unsuccessful. Emergency Medical Services (EMS) was called, and Resident #23 was taken to the hospital for an evaluation. On 8/6/24 at 8:41 AM Resident #23 was observed asleep in his room. He did not respond to attempts to speak with him. On 8/6/24 at 11:49 AM an interview with Nurse #1 indicated she recalled the incident with Resident #23 that occurred on 7/25/23. She stated Resident #26 did not usually walk, but on this occasion had gone into the bathroom that his room shared with an adjoining room, became confused, and exited into another resident's room (Resident #33) instead of his own. Nurse #1 stated Resident #23 had been found sitting on the end this resident's bed. She went on to say she ensured the other resident (Resident #33) was safe by having someone assist her into the activity room. She reported when an attempt was made to redirect Resident #23 back into his room, he became very agitated, got up, and started banging the window blinds against the window. She went on to say she attempted to contact Resident #23's family member to help calm him down. Nurse #1 stated when this was not successful, EMS was called and Resident #23 was taken to the ED for an evaluation. She reported the other resident (Resident #33) was alert and oriented and been very understanding and not upset by the incident at the time.	F 626	Residents to Return to Facility. Quality Assurance The results of these audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator and or Director of Nursing, and reviewed by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 8/26/2024	

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On 8/5/24 at 11:05 AM an interview with Resident #33 indicated she recalled the incident on 7/25/23 when Resident #23 sat on the end of her bed. She stated she had not been upset or afraid and had not been hurt during the incident. She reported this was the only incident she ever had involving Resident #23.

A review of a nursing progress note for Resident #23 dated 7/25/23 at 5:58 PM written by the facility's Director of Nursing (DON) revealed she received a call from the hospital regarding Resident #23. It further indicated she told the hospital Resident #23 would need to have a psychiatric evaluation to determine if he could return to the facility or if he might be a better fit at another facility.

On 8/6/24 at 12:26 PM an interview with the DON indicated Resident #23 had multiple interventions in place regarding his behaviors. She stated usually if his family member was involved when he became agitated, he could be calmed and reassured. She reported on 7/25/23, this had not been the case. The DON further indicated she had felt that for Resident #23's safety and the safety of other residents he needed to be evaluated in the hospital to determine if he should remain at the facility. She reported with regards to Resident #23 returning to the facility, there would not have been just one person involved in making this decision. She stated this would have involved the interdisciplinary team.

A review of a hospital psychiatric evaluation for Resident #23 dated 7/25/23 at 7:50 PM revealed after Resident #23 had an episode of slamming the blinds in another patient's room, the nursing

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facility had him taken to the Emergency Department (ED) and refused to take him back until a psychiatric evaluation was done. Resident #23 did not appear to be a danger to himself or others and did not meet the criteria for psychiatric hospitalization. Resident #23's disposition (placement) would be turned back over to the ED.

A review of a Notice of Termination/Discharge with appeal rights dated 7/27/23 revealed in part Resident #23 was being discharged from the nursing facility because it was necessary for his welfare and his needs could not be met at the facility. It further revealed the safety of individuals in the facility was endangered because of Resident #23's clinical or behavioral status. The notice was signed by the nursing facility's Administrator #2 and indicated a copy of the notice had been sent to the LTC Ombudsman.

A review of a hospital physician progress note for Resident #23 dated 7/27/23 at 3:21 PM revealed Resident #23 became agitated while in the ED the previous evening (7/26/23) when the nurse attempted to check his vital signs, and he required a dose of haloperidol (an antipsychotic medication). He became drowsy and slept the rest of the night. Resident #23's family member was with him, and reported she had been informed that the nursing facility was discharging Resident #23. Resident #23's family member had filed a report with the State Agency and had been working with the Ombudsman. The ED Case Manager was searching for another nursing facility for Resident #23.

A review of the ED Case Manager's progress note dated 7/27/23 at 3:42 PM, which indicated it was a late entry, revealed she spoke with the

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Regional Marketing Director of Resident #23's nursing facility and was told that per the nursing facility's Regional Vice President (VP) Resident #23 would not be allowed to return to the facility. The ED Case Manager had consulted with the Long Term Care (LTC) Ombudsman regarding Resident #23's situation, and the LTC Ombudsman would follow-up with Resident #23's family and the nursing facility.

On 8/7/24 at 9:18 AM a telephone interview with the ED Case Manager indicated Resident #23 had been sent to the hospital ED by his nursing facility (7/25/23) after an incident at the facility. She went on to say Resident #23 had a family member with him the entire time he was in the hospital, and there were no instances of distress for the resident. She stated the facility's Director of Nursing had wanted a medication review and a psychiatric evaluation before allowing Resident #23 to return to the facility. She reported Resident #23 had these completed, and when the hospital was ready to send Resident #23 back to the facility, the facility Regional Marketing Director told her the facility would not be taking Resident #23 back. The ED Case Manager went on to say she contacted the LTC Ombudsman for assistance. She stated she received Resident #23's discharge notice from the facility on 7/27/23 at 11:49 AM and provided this to Resident #23's family member. She reported at 3:23 PM that same day she received the report that the nursing facility would take Resident #23 back.

On 8/8/24 at 10:24 AM a telephone interview with Resident #23's family member indicated Resident #23 had remained in the hospital ED after the hospital cleared him to return to the facility on 7/25/23. She stated the nursing facility was not

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going to allow Resident #23 to return. She went on to say it took her reaching out to the State Agency before the facility would allow Resident #23 to return. She reported she worked closely with the LTC Ombudsman. Resident #23's family member stated after the State Agency intervened, Resident #23 had been allowed to return to the facility on 7/27/23 and remained at the nursing facility with no further issues. She stated while she felt the stress Resident #23 experienced being in the ER those days was unnecessary, she did not indicate Resident #23 experienced any harm.

On 8/8/24 at 11:58 AM a telephone interview with the facility's Regional Marketing Director indicated the decision for Resident #23 not to be able to return to the facility would have been made by Administrator #2 and the Regional Vice President. She stated she would not be involved in this type of decision making.

On 8/8/24 at 12:23 PM an attempt at a telephone interview with the Regional Vice President was unsuccessful.

On 8/6/24 at 1:08 PM a telephone interview with the LTC Ombudsman indicated she was familiar with Resident #23. She stated he didn't come out of his room very often. She reported on 7/25/23, he became confused and exited the bathroom into an adjoining room and refused to come out. She further indicated he was sent to the hospital and when the hospital was ready to send Resident #23 back to the facility, Administrator #2 refused to take Resident #23 back. The LTC Ombudsman stated on 7/27/23 the nursing facility provided a discharge notice with appeal rights, and she filed for an expedited appeal hearing.

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She reported Resident #23's family member called the State Agency, and when the State Agency became involved the nursing facility took Resident #23 back. She went on to say it was her understanding that Resident #23 had a family member with him the entire time he was in the hospital.

On 8/8/24 at 8:15 AM a telephone interview with Administrator #2 indicated she recalled the incident with Resident #23 on 7/25/23 where he was unexpectedly able to get up and go into the bathroom. She stated this bathroom adjoined his room and the room of another resident. She went on to say Resident #23 had become confused, and gone into the other resident's room, became very agitated and combative, and refused to leave. She reported while Resident #23 had episodes of verbal and physical aggression towards staff, he had never done anything like that before and she felt the facility needed help managing this behavior. Administrator #2 stated Resident #23 needed to be transferred to the hospital for an evaluation. She indicated she had spoken to Resident #23's family, the State Agency, and the LTC Ombudsman. She went on to say the facility had rooms available, but not any rooms that did not have adjoining bathrooms at the time Resident #23 was ready to come back from the hospital, and she had needed time to coordinate room rearrangements with other residents and their families.

On 8/8/24 at 1:34 PM in a telephone interview the facility's Corporate Nurse Consultant stated she had been involved in conversations with the facility regarding Resident #23's return from the hospital. She reported it was her understanding that the facility had not ever refused to take

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F 626	Continued From page 9 Resident #23 back. She did not explain why the facility issued the notice of discharge dated 7/27/23 and it had taken from 7/25/23, when Resident #23 had been cleared by the psychiatric evaluation to return to the facility, until 7/27/23 when the State Agency and the LTC Ombudsman became involved for him to be allowed to return. The Corporate Nurse Consultant stated she did know that it took some time for the facility to rearrange rooms so that it would be safe for the Resident #23 to return to the facility.	F 626		
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:	F 700		8/26/24

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F 700	Continued From page 10 Based on observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing siderails (also known as bedrails), complete siderail assessments, assess entrapment risk, review the risks and benefits of siderails with the resident /resident representative and obtain informed consent prior to siderail use for 2 of 2 residents (Resident #24, Resident #37) reviewed for siderails. Findings included: 1. Resident #24 was admitted to the facility on 12/6/2023 with a diagnosis of hemiplegia (complete paralysis) and hemiparesis (partial muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side. A review of Resident #24's electronic chart revealed no siderail screening. A screening titled "Restraint and Adaptive equipment observation" dated 5/30/24 was reviewed. The screening indicated Resident #24 did not use adaptive equipment. The observation was completed by the Assistant Director of Nursing (ADON). A Significant Change Minimum Data Set (MDS) dated 6/5/24 revealed Resident #24 was cognitively intact. The MDS indicated Resident #24 required total assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #24 had an impairment of both upper and lower extremities. The MDS indicated Resident #24's siderails were not used as a restraint. A care plan with the latest review date of 8/5/24 revealed a problem of using 1/4 siderails to	F 700	Corrective Action for the Resident Affected On 08/08/2024, the DHS, assessed, resident #24 and Resident #37, using the Restraint Adaptive Equipment Use/Side Rail Assessment form and Consent per facility Bed Rail policy. The assessments indicated that the side rails were medically necessary for each resident and that the resident and or resident□s representative requested the side rails. On 08/08/2024, the Maintenance Director, (MD) examined the bed rails for resident #24 and #37 to ensure proper operations and bed for appropriateness for resident size and weight per the manufacture□s recommendations. No changes were needed for each resident. Action for the Residents Potentially Affected On 08/08/24, the Director of Healthcare Services, (DHS) and Administrative Nurses, initiated the Restraint Adaptive Equipment Use/Side Rail Assessment Observations audit on the remaining 52 residents. Of the remaining 52 residents, 51 residents met the criteria for bed rails and consents were received. The 1 resident that did not meet the bed rail criteria, the facility did not place side rails on bed. On 08/19/2, the MD initiated examining the 51 beds to ensure that the bed dimensions were appropriate for the	

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F 700	Continued From page 11 aid/promote independent bed mobility. The goal was Resident #24 would not sustain any injuries related to the use of siderails through next review. Interventions included ensuring siderails were installed properly, do not promote entrapment and Restraint/Adaptive Equipment observation was completed quarterly and as needed. An observation on 8/5/2024 at 2:27 PM revealed Resident #24 resting in bed with bilateral one-quarter length siderails in the up position on the bed. An observation 8/6/2024 at 10:00 am revealed Resident #24 awake in bed with bilateral one-quarter length siderails in the up position on the bed. An interview with Nurse #1 on 8/7/24 at 12:28 PM revealed the Nurses filled out the restraint and adaptive equipment screening on admission and quarterly. Nurse #1 stated this form was what they used for siderail screening. She further stated she always answered no to the question "is adaptive equipment in use" as she did not see siderails as adaptive equipment. Nurse #1 revealed there was no specific siderail assessment available. Nurse #1 indicated that siderails were on the beds on admission and stayed on the beds even when there was no resident admitted to that bed. She further indicated Nursing did not try alternatives to siderails before they were used. She was not aware of who was responsible for reviewing the risks and benefits with the resident or their representative, assessing entrapment risk, and obtaining the resident or the residents responsible party's consent for siderail use.	F 700	resident□s size, height and or weight. Of the 51 beds examined, 4 residents required a special bed to accommodate their size, height and weight. The remaining 48 resident□s beds were appropriate for their size, height and weight. Systemic Changes On 08/07/24, the Regional Nurse Consultant in-serviced the Administrator, DHS and Maintenance Director about Bed rail policy, to and including that residents are to be assessed upon admission, every 90 days during their assessment Minimum Data Set, (MDS) window and change of condition. On 08/08/24, the DHS initiated an in-service for all licensed nurses on initiating the Restraint Adaptive Equipment Use/Side Rail Assessment form on new admissions/re-admissions/90-day assessments and or change of condition. This policy will be reviewed during orientation with newly hired licensed nurses. On 08/20/2024, the Administrator in-serviced the disciplinary team, Case Mix Nurse, Activities Coordinator, Social Worker, Dietary Manager, and Therapy Director on the Restraint Adaptive Equipment Use/Side Rail Assessment form on new admissions/re-admissions/90-day assessments and or change of condition. The Administrator and or DHS will	

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F 700	Continued From page 12 A telephone interview with the ADON on 8/7/24 at 12:09 PM revealed she completed the restraint and adaptive equipment observation for Resident #24 on 5/30/24 and she marked no to the question if adaptive equipment was in use. She stated she did not see siderails as adaptive equipment. The ADON further stated there was not a specific siderail assessment form for them to complete. In a follow-up telephone interview with the ADON on 8/8/24 at 11:25 AM she stated siderails were on the bed at admission. She further stated they did not attempt interventions before implementation of siderails. The ADON revealed she was unaware of who was responsible for assessment of entrapment risk prior to installation, who discussed risks and benefits of siderail use, or who obtained informed consent from the resident or the resident's responsible party. In a telephone interview with the Director of Nursing (DON) on 8/8/24 at 11:55 AM she stated Nursing completed the restraint and adaptive equipment observation for use of siderails and she was unaware the Nurses had not understood that siderails were considered adaptive equipment until it was brought to her attention during this recertification survey. She further stated the Nurses should have answered yes to the question if adaptive equipment was in use. The DON revealed there was no assessment regarding entrapment risk, discussion of risks and benefits with the resident or their responsible party, or informed consent on the form. She further revealed she thought that the discussion of risks and benefits and informed consent was received on admission although she did not know	F 700	randomly select 2 residents weekly times 4 weeks, 2 residents monthly, times 3 months, that have been recently admitted or had a new assessment completed, per the facility policy, utilizing the Quality Assurance Monitoring Tool Bed rails. Quality Assurance The results of these audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator and or Director of Nursing, and reviewed by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 08/26/2024	

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where that was documented. The DON indicated there was no other siderail assessment available for Nursing to complete.

An email from the Administrator on 8/8/24 revealed the facility did not have a form for informed consent for the use of siderails.

In a telephone interview with the Administrator on 8/8/24 at 2:50 PM she indicated she thought the restraint and adaptive equipment observation form was meant to include siderails. She was unaware alternatives to siderails needed to be tried and documented before siderails were approved. The Administrator further stated the restraint and adaptive equipment observation form did not address entrapment risk, discussion of risk and benefits regarding siderail use with the resident or their responsible party, informed consent for the use of siderails or alternatives tried beforehand. She indicated Nursing should have had that discussion with the Resident or their responsible party before using siderails. The Administrator revealed she chose the forms the staff completed from options given by the corporate office, and she had been using the restraint and adaptive equipment observation form. She stated she has looked through the options since the issue was brought to her attention during this recertification survey and she had found one specifically for siderails.

2. Resident #37 was admitted to the facility on 12/12/23 and readmitted on 7/23/24 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), encephalopathy (brain dysfunction) and general muscle weakness.

A review of Resident #37's electronic chart

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revealed no siderail screening. A screening titled "Restraint and Adaptive Equipment observation" dated 5/17/24 was reviewed. The screening indicated Resident #37 did not use adaptive equipment. It was completed by Nurse #1.

A 5 day Minimum Data Set (MDS) dated 7/30/24 revealed Resident #37 was cognitively intact and had no impairment of upper or lower extremities. The Resident was independent with rolling in bed, sitting to lying and lying to sitting in bed. The MDS indicated Resident #37's siderails were not used as a restraint.

A care plan with the latest review date of 8/5/24 revealed a problem of using 1/4 siderails to aid/promote independent bed mobility. The goal was Resident #37 would not sustain any injuries related to the use of siderails through next review. Interventions included ensuring siderails were installed properly, do not promote entrapment and Restraint/Adaptive Equipment observation was completed quarterly and as needed.

An observation on 8/5/2024 at 8:38 AM revealed Resident #37's bed with the one-quarter length siderails in the raised position. Resident #37 was not in bed.

An observation 8/6/2024 at 10:15 am revealed Resident #37's bed with bilateral one-quarter length siderails in the up position on the bed. Resident #37 was not in the bed.

The interview with Nurse #1 on 8/7/24 at 12:28 PM revealed she filled out the restraint and adaptive equipment screening for Resident #37 on 5/17/24. Nurse #1 stated this form was what they used for siderail screening. She further

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stated she always answered no to the question "is adaptive equipment in use" as she did not see siderails as adaptive equipment. Nurse #1 revealed there was no specific siderail assessment available. Nurse #1 indicated that siderails were on the beds on admission and stayed on the beds even when there was no resident admitted to that bed. She further indicated Nursing did not try alternatives to siderails before they were used. She was not aware of who was responsible for reviewing the risks and benefits, assessing entrapment risk, and obtaining the resident or resident representatives consent for siderail use.

A telephone interview with the Assistant Director of Nursing (ADON) on 8/7/24 at 12:09 PM revealed Nursing used the restraint and adaptive equipment observation assessment for siderail assessment. She stated she marked no to the question if adaptive equipment was in use as she did not see siderails as adaptive equipment. The ADON further stated there was not a specific siderail assessment form for them to complete.

In a follow-up telephone interview with the ADON on 8/8/24 at 11:25 AM she stated siderails were on the bed at admission. She further stated they did not attempt interventions before implementation of siderails. The ADON revealed she was unaware of who was responsible for assessment of entrapment risk prior to installation, who discussed risks and benefits of siderail use, or who obtained informed consent from the resident or the resident's responsible party.

In a telephone interview with the Director of Nursing (DON) on 8/8/24 at 11:55 AM she stated

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Nursing completed the restraint and adaptive equipment observation for use of siderails and she was unaware the Nurses had not understood that siderails were considered adaptive equipment until it was brought to her attention during this recertification survey. She further stated the Nurses should have answered yes to the question if adaptive equipment was in use. The DON revealed there was no assessment regarding entrapment risk, discussion of risks and benefits with the resident or their responsible party, or informed consent on the form. She further revealed she thought that the discussion of risks and benefits and informed consent was received on admission although she did not know where that was documented. The DON indicated there was no other siderail assessment available for Nursing to complete.

An email from the Administrator on 8/8/24 revealed the facility did not have a form for informed consent for the use of siderails.

In a telephone interview with the Administrator on 8/8/24 at 2:50 PM she indicated she thought the restraint and adaptive equipment observation form was meant to include siderails. She was unaware alternatives to siderails needed to be tried and documented before siderails were approved. The Administrator further stated the restraint and adaptive equipment observation form did not address entrapment risk, discussion of risk and benefits regarding siderail use with the resident or their responsible party, informed consent for the use of siderails or alternatives tried beforehand. She indicated Nursing should have had that discussion with the Resident or their responsible party before using them. The Administrator revealed she chose the forms the

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F 700	Continued From page 17 staff completed from options given by the corporate office, and she had been using the restraint and adaptive equipment observation form. She stated she has looked through the options since the issue was brought to her attention during this recertification survey and she had found one specifically for siderails.	F 700		