STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345203	A. BUILDING _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BANNER ELK	185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604

(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
E 000	Initial Comments An unannounced recertification survey was conducted from 08/18/2024 through 08/21/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BZQX11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 08/18/24 through 08/21/24. Event ID # BZQX11.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		9/12/24

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

Electronically Signed | 09/12/2024

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F 565	Continued From page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to provide a resolution of Resident Council grievances for 1 of 1 monthly Resident Council Meetings (June 2024). The Resident Council had reported they would like to have transportation to go on group outings. The findings included: A review of the Grievance Program policy dated 5/6/2019 stated the facility should make prompt efforts to resolve a grievance and should actively work toward a solution of a complaint/grievance. The facility should follow up with the resident to communicate resolution or explanation and ensure that the issue was handled to the resident's satisfaction. A review of the Resident Council minutes from 6/24/2024 revealed residents requested to take day trips and were advised that the facility had contacted companies regarding party buses for transportation and the prices were too expensive. The Activities Director (AD) had called local rafting companies that had large buses, and none were handicap accessible. The AD was to contact the local transportation agency.	F 565	F565 Resident Family Group and Response 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 08/28/24, the Executive Director (ED) attended the August 2024 Resident Council meeting and further explained the plans and processes in place to resolve the grievance regarding resident outings. The members of the Resident Council accepted the plan in place to correct this practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. On 09/09/24, Executive Director (ED) and Social Services Director (SSD) reviewed and completed a 100% audit of all Comment	

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F 565	Continued From page 2 A review of a grievance filed on 6/24/2024 by the Activities Director (AD) revealed residents had requested the facility to find transportation to ride around and get lunch. The AD advised residents that she had contacted local rafting companies to see if their bus was handicap accessible and was told they were not. The AD advised the residents that she would contact the local transportation company. The grievance form indicated the facility was not able to resolve the concern at the time it was shared. The Administrator was assigned the grievance. The investigation steps stated, "at this time staffing restraints are hindering resident outings." Documented actions taken to resolve/respond to the concerns stated, "will continue to try to hire a driver and will also consider ordering special meals in for the residents upon request." There was no documented date, time, findings, or action plan for when the information was shared with the concerned party and the concerned party's response to the action plan/outcome was "disappointed." The grievance was signed by the Administrator on 6/27/2024. An interview was conducted on 8/19/2024 at 10:41 am with the AD. The AD stated the resident council met once a month and had requested to go on day trips. The AD stated day trips were not possible at the time because the facility did not have a van driver. The AD stated that she had called the local transportation company in the past and was told that there was a charge for transportation if the reason for transport was not for a medical need. The AD was unsure of when she had reached out to the local transportation agency and stated that when they had used them for a non-medical	F 565	and Concern cards for the past 6 months. All other grievances were identified as resolved with documentation of outcome. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 09/10/24, the Regional Vice President provided education to the ED regarding the grievance policy and ensuring proper notification is made to those filing the complaint, even if the issue could not be immediately resolved to their satisfaction. Beginning on 09/09/2024, the Staff Development Coordinator (SDC) provided education to all Department heads on the Grievance Policy, including proper notification of outcome to parties filing the grievance. This education was completed by 09/11/2024. The SDC and/or ED will provide this same education to all new Department heads upon hire, and as necessary. Beginning on 09/02/24, all Comment and Concern cards will be logged and reviewed daily Monday □ Friday by the ED and/or Director of Nursing (DON) and/or SSD during daily stand-up meeting and/or Clinical Rounds. The SSD will be responsible for maintaining log and ensuring all Comment and Concern Cards are addressed timely.	

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F 565	Continued From page 3 appointment in the past, it was very expensive. An interview was conducted on 8/20/2024 at 12:33 pm with the Social Services Director. The Social Services Director stated the Grievance Official was the Administrator and that a grievance could be filled out by anyone in the facility. The Social Services Director stated she received all grievances, made a copy of the grievance and wrote the information from the grievance on the grievance log. She stated she gave the grievance to the appropriate department manager and once the grievance was resolved, or if the facility was not able to come to a resolution, the grievance was discussed with the person who filed the grievance, and the Administrator signed the grievance as completed. The Social Services Director stated she was aware members of the Resident's Council had expressed wanting to go on group outings. The Social Services Director stated any interventions, or resolution should have been documented on the grievance form and stated she did not think any interventions or resolutions had been agreed upon. An interview was conducted on 8/20/2024 at 1:18 pm with the Administrator. The Administrator stated anyone at the facility could complete a grievance. The Administrator stated she was the Grievance Official and the Social Services Director was responsible for keeping a log of the grievances and distributed the grievances to the appropriate department manager. The Administrator stated after a grievance was completed, the staff discussed the status of grievances in their morning meetings until the grievance was resolved. The Administrator stated she was under the impression that the	F 565	The log will include the date of grievance, subject of concern, which department head is assigned to follow-up, what actions were immediately taken to attempt to resolve the concern, and ultimately how it was addressed and when complainant was notified of the outcome. This log will be reviewed until each grievance is completed and resolved. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The ED will complete an audit of the Concern and Comment Card Log, reviewing all cards for completion and ensuring the resolution is provided to the party filing the complaint, prior to signing off on the card. If a concern was expressed by a group of residents or family members rather than just an individual, the SSD or ED will ensure all parties involved received communication regarding the resolution. If the situation, cannot be resolved, there will be documentation provided to the complainants regarding reasons and alternative actions which may be taken. Any omission identified in this audit will be addressed and re-education provided to parties involved. This audit will be completed 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then 1 time a week for 4	

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F 565	Continued From page 4 residents knew that outings were not feasible at this time due to the facility not having a van/bus driver. The Administrator stated she knew a few months ago the AD had reached out to the local transportation agency and at the time it was too expensive for non-medical trips and the agency did not have a lot of availability. The Administrator stated she had not contacted the local transportation agency or tried to arrange transportation for outings recently, however the facility had advertised for a van/bus driver. The Administrator stated that she should have made sure the residents knew that the grievance could not be resolved, and that the facility would continue to work on hiring a van/bus driver to take the residents on group outings.	F 565	weeks. The Director of Nursing and/or Executive Director will present monthly for three (3) months, the results of the audits and education as indicated to the facility Performance Improvement (PI) Committee. This committee consisting of the Executive Director, Director of Nursing, Medical Director, Director of Maintenance, Director of Rehab, Health Information Management Director, Director of Food and Nutrition Services, Director of Social Services, Business Office Manager, Director of Admissions, and Director of Activities will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant. 5. Date when corrective action will be completed. 09/12/2024	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		9/12/24

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F 679	Continued From page 5 Based on record reviews, facility activity calendars, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 5 residents reviewed for activities (Resident #7, #22, #28, #21). The findings included: A review of the Resident Council Minutes from July 2023 through July 2024 revealed the following: -July 2023 the residents had discussed trips that might be fun when activities were able to provide group trips. Residents #22 and Resident #7 were in attendance. -September 2023 the residents had discussed wanting to take short trips on the Parkway to see the leaves change. Residents #7, #22, #28, #21 were all in attendance. There was no documented response to the residents request for a group outing. -October 2023 the residents had discussed wanting to take short trips on the Parkway to see the leaves change. Residents #7, #28, #21 were all in attendance. There was no documented response to the residents request for a group outing. -March 2024 the resident had discussed they would like to go on short trips, to the store or Subway, on the van. Activities was going to looking to the dynamics of the van and transportation rules and would report back to	F 679	F679 Activities Meet Interest/Needs Each Resident 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 08/28/24, the Executive Director (ED) attended the August 2024 Resident Council meeting and was able to discuss the type of outings we could facilitate and the members of the resident council expressed understanding to keep it small at first with local trips including 3-4 residents per trip. The first 2 trips were planned for 09/10/24 and 09/18/24. On 09/10/24, the Executive Director (ED), Activities Director (AD), and 2 other staff members completed an outing for 3 residents agreed upon by the members of the Resident Council. The Director of Maintenance drove the facility bus to a local shopping center with 3 residents, all using wheelchairs as primary source of assistive device. Resident # 7 went on this trip. Residents # 21 and #22 plan to go on the 9/18/24 outing and resident #28 declined the invitation. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. On 08/28/24,	

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F 679	Continued From page 6 Resident Council. Residents #7, #22, #28, #21 were all in attendance. There was no documented response to the residents requests for a group outing. -April 2024 the residents were informed that the Activities Assistant had left his position and that short trips on the van would not be possible until a driver was hired. Residents #7, #22, and #28 were all in attendance. There was no documented response to the residents request for a group outing. -May 2024 residents had discussed they were still wanting to go on day trips and would like for activities to look into renting a party bus so many residents could attend. Resident #7, #22, #28, #21 were all in attendance. There was no documented response to the residents request for a group outing. -June 2024 residents were advised that the facility had "looked into party buses and their prices were just too expensive and had called local rafting companies that have large buses, but none were handicap accessible." The residents were informed the Activities Director (AD) had inquired about renting a party bus and the prices were too expensive. The AD had also contacted local rafting companies that had larger buses and none of the buses were handicap accessible. The AD was going to contact the local transportation agency. Residents #22 and Resident #7 were in attendance. There was no documented response to the residents request for a group outing. -July 2024 there was no documented response to the residents request for a group outing.	F 679	the ED and AD attended the Resident Council meeting where residents had the ability to state preferences for outings that would meet their interest. A few residents stated that they might participate in outings if it was something they wanted to do and the weather was good. They were noted by the AD to have shown interest in future outings. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning on 09/10/24, the ED provided education to the Activities Director and Activity Assistants regarding how they could identify residents who expressed the desire to go on outings. This topic will be covered monthly in the Resident Council Meeting as well. Education was completed on 09/12/24. At this time, bus outings will be scheduled at least once a month, weather permitting with a rotation of residents having the opportunity to attend and feedback will be gathered after each trip. Beginning on 09/04/24, the AD began interviewing residents both that attend Resident Council and those who do not routinely attend about their interest in outings outside the facility and an ongoing log will be updated as needed but no less than each Resident Council Meeting.	

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F 679	Continued From page 7 A Resident Council meeting was conducted on 8/21/2024 at 9:59 am with Residents #7, #22, #28, and #21 in attendance. The residents expressed that they had been asking about going on a group outing repeatedly during their Resident Council meetings. The facility staff had responded to the residents that there was no transportation, van/bus driver, and not enough staff to go on group outings at this time. During the Resident Council meeting Resident #7 stated she would like to go to the dollar store and had not been in a store in several years. Resident #22 stated the residents had been told they did not have transportation for group outings. Resident #22 stated not being able to go on group outings felt like "being in prison." Resident #21 stated she would love to get out of the facility and go to a store because she wanted "to be able to pick out her own stuff, but it with her own money, and feel like an addition to society." An observation was conducted on 8/20/2024 at 12:00 pm revealed the facility was within driving distance of local restaurants (0.8 miles), local stores (6.4 miles), and a park (2.8 miles). a. Resident #7 was admitted to the facility on 9/23/2021. A review of an annual Minimum Data Set (MDS) dated 3/21/2024 revealed Resident #7 was cognitively intact, and it was "very important" to do things with groups of people and to go outside to get fresh air when the weather is good. An interview was conducted on 8/19/2024 at 9:22 am with Resident #7. Resident #7 stated she regularly attended Resident Council and activities	F 679	4. How the facility plans to monitor its performance to make sure that solutions are sustained. The ED will complete an audit of the posted activities calendar of events monthly by the 5th of each month to ensure there is an outing offered outside of the facility. The ED will review Resident Council minutes monthly within 5 days of the meeting. The ED will ensure any concerns or suggestions related to activities meeting the needs of the residents are addressed timely and if they cannot be resolved immediately, that there is documented communication between the parties involved. Each audit will be completed monthly x 3 months. Any omission identified in this audit will be addressed and re-education provided to parties involved. The Executive Director or Activities Director will present monthly for three (3) months, the results of the audits and education as indicated to the facility Performance Improvement (PI) Committee. This committee consisting of the Executive Director, Director of Nursing, Medical Director, Director of Maintenance, Director of Rehab, Health Information Management Director, Director of Food and Nutrition Services, Director of Social Services, Business	

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F 679	Continued From page 8 at the facility. Resident #7 stated that since she had been admitted, she had never been on an outing and wanted to go. Resident #7 stated the residents had been told there was no transportation to be able to take them on outings. Resident #7 stated she would love to go to a store and stated that not being able to go on outings "felt kind of like being in jail." b. Resident #22 was admitted to the facility on 10/16/2022. A review of a change in condition Minimum Data Set (MDS) dated 11/21/2023 revealed Resident #22 was cognitively intact, and it was "very important" to do things with groups of people and to go outside to get fresh air when the weather is good. An interview was conducted on 8/18/2024 at 3:49 pm with Resident #22. Resident #22 stated she had been at the facility for a couple of years and was the Resident Council President. Resident #22 stated the residents had not been on a group outing since she was admitted to the facility. Resident #22 stated the residents had expressed wanting to go on group outings just go "get out." Resident #22 stated not being able to go on outings "really bothered" the residents. c. Resident #28 was admitted to the facility on 10/10/2018. A review of an annual Minimum Data Set (MDS) dated 5/24/2024 revealed Resident #28 was cognitively intact, and it was "very important" to do things with groups of people and to go outside to get fresh air when the weather is good.	F 679	Office Manager, Director of Admissions, and Director of Activities will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant. 5. Date when corrective action will be completed. 09/12/2024	

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An interview was conducted on 8/19/2024 at 9:28 am with Resident #28. Resident #28 stated he had been at the facility for six years, had regularly attended Resident Council and activities, and had never been on a group outing. Resident #28 stated it made him "feel terrible" to not be able to go on group outings. Resident #28 stated his family was not able to take him out of the facility and he would "just like to go out to a restaurant to eat."

d. Resident #21 was admitted to the facility on 12/23/2024.

A review of an annual Minimum Data Set (MDS) dated 5/7/2024 revealed Resident #21 was cognitively intact, and it was "very important" to do things with groups of people and to go outside to get fresh air when the weather is good.

An interview was conducted on 8/19/2024 at 9:31 am with Resident #21. Resident #21 stated she had been at the facility for four years and had never been on a group outing. Resident #21 stated the only time she had left the facility was to go to doctor appointments. Resident #21 stated the residents had been told the facility did not have a transportation van that was big enough or enough staff to be able to help.

An interview was conducted on 8/19/2024 at 10:41 am with the Activities Director (AD). The AD stated she had worked at the facility for four and a half years and transferred to the Activities Director position about a year and a half ago. The AD stated the residents had mentioned wanting to take day trips that were unrealistic because the facility did not have a driver for the van. The AD stated the residents had not been

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F 679	Continued From page 10	F 679		

on a group outing since before Coronavirus. The AD stated the facility did not have transportation large enough to support the amount of residents that would want to go, and there was not enough staff to take them. The AD stated most of the residents would require assistance with transfers and toileting, which would require one staff member to one resident for safety purposes. The AD stated she had called local rafting companies about transporting residents on their vans/buses but was told the vans/buses were not handicap accessible. The AD stated she had also reached out to a local transportation agency and stated they would charge if the transportation was not for a medical necessity. The AD stated if she was not able to go out on outings she would feel "land locked." The AD stated she did not feel comfortable driving the van in the event something bad happened. The AD stated the van could hold approximately 2 residents in wheelchairs. The AD stated she would have felt bad if she took only 2 out at a time because that would make other residents feel like they were left out and would not be fair.

An interview was conducted on 8/19/2024 at 11:18 am with the Administrator. The Administrator stated several of the residents had mentioned wanting to go on group outings but stated that transportation was a huge issue in their county along with the fact that everyone wanted to go. The Administrator stated the facility took the residents outside when the weather was good and provided a variety of entertainment groups. The Administrator stated they started the Resident Council Store which gave the residents an opportunity to feel like they were shopping at a real store. The Administrator stated the AD had made efforts to try to find

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	345203	A. BUILDING _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BANNER ELK	185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604

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F 679	Continued From page 11 transportation but that between the lack of a van driver and not having enough staff, it was not feasible to go on outings at this time. The Administrator stated the bus would hold a couple of wheelchairs and several ambulatory residents. The Administrator stated she did not feel comfortable driving the van or bus and being responsible for the residents while they were on an outing if something bad were to happen. An interview was conducted on 8/20/2024 at 9:23 am with the Maintenance Director. The Maintenance Director stated the facility had a transportation van and a bus. He stated the van would hold approximately 2 residents and the bus could hold approximately 3 wheelchairs and several other residents that were ambulatory. The Maintenance Director stated that anyone with a driver's license could drive the van, or the bus and no special credentials were needed. The Maintenance Director stated he occasionally went to the hospital to pick up residents in the van, but primarily was only responsible for maintenance duties in the facility.	F 679		
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.	F 700		9/12/24

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F 700	Continued From page 12 §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, record reviews and staff interviews, the facility failed to complete bed rail assessments to determine the need for bed rails for 2 of 9 residents reviewed for accidents (Resident #3 and Resident #45). Findings Included: 1. Resident #3 was admitted to the facility 10/06/22 with diagnoses that included history of repeated falls, status post fracture of the superior rim of the left pubis (a bone of the pelvis) and dementia. The annual Minimum Data Set (MDS) assessment dated 07/25/24 assessed Resident #3 with short and long term memory problems. The MDS also indicated she had functional range of motion impairment on one side of her lower extremity and required substantial to maximal assistance from staff to roll from left to right. The MDS revealed bed rails were not used as a restraint. A review of Resident #3's electronic medical record revealed there had not been a bed rail	F 700	F700 - Bedrails 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 8/20/24, Maintenance removed the bed rails from the bed of Resident #45's bed after reassessment. Resident #3 was reassessed for the use of side rails and it was determined that she should have them. Quarterly assessments were scheduled for these residents and consents were confirmed to be in chart. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. On 8/20/24, a 100% audit was completed	

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F 700	Continued From page 13 assessment completed since her admission on 10/06/22. An observation of Resident #3 on 08/18/24 at 4:00 PM revealed she was lying in her bed on her back sleeping with the bilateral quarter bed rails in the up position. During an interview with Nurse Aide (NA) #1 on 08/18/24 at 4:11 PM, the NA explained that Resident #3 had a fall from her bed "a while back" that fractured some of the bones in her pelvis. The NA stated the Resident was total care with the assistance of two staff but she would attempt to feed herself when sitting up. On 08/19/24 at 2:19 PM an observation was made of Resident #3 lying on her back in her bed with the bilateral quarter bed rails in the up position. During an interview with NA #2 on 08/19/24 at 4:10 PM the NA explained that Resident #3 had a fall from her bed several months ago that broke a bone around her pelvis and since then she seemed to decline. The NA stated Resident #3 required two staff assist to turn in the bed but would hold the bed rail if her hand was put in that position. An interview conducted with Nurse #1 on 08/20/24 at 2:09 PM revealed Resident #3 had declined since she fractured her pelvic bones from a fall. The Nurse explained that the Resident required two staff assist with most of her activities of daily living including rolling from side to side in the bed. She indicated Resident #3 could hold the side rail if you put her hand in that position but could not actively roll herself. Nurse #3 continued	F 700	by Director of Nursing (DON) with the assistance of a Licensed Practical Nurse (LPN). Audit was for all residents at facility to check beds for side rail use and non-use and appropriate documentation in chart. Any discrepancies identified in the audit were corrected by 09/03/24. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Beginning 9/3/2024, the Staff Development Coordinator (SDC) and/or DON provided education to all licensed nurses (RN and LPN), certified nursing assistants, maintenance, social services, and all non-licensed staff on the proper use of bed rails. This education was completed on 9/12/2024. The SDC and/or the DON will provide this same education to all new hires and as necessary. Beginning on 09/09/24, all new residents will be assessed for side rails upon admission and quarterly thereafter and these will be added to the audit tool. The DON will review the charts of all new admissions to ensure that the initial assessment, quarterly assessments, consent, and order are in place. The admission check list has been updated to include a check off option for bed rail assessment, initial and quarterly, consent, order, care plan, and Kardex. MDS coordinator will ensure that the side rails are added to the care plan and the	

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F 700	Continued From page 14 that bed rail assessments were completed quarterly but when she reviewed the Resident's electronic medical record for the last assessment, she stated there was no bed rail assessment in the medical record. During an interview with the Director of Nursing (DON) on 08/20/21 at 3:40 PM the DON explained that the bed rail assessments were supposed to be done quarterly along with the MDS assessments. She stated they discovered a glitch in the system that prevented the bed rail assessments from automatically popping up to be completed. 2. Resident #45 was admitted to the facility on 6/8/2021 with diagnoses which included Alzheimer's disease and dementia. A review of Resident #45's Medical Record revealed an Evaluation for Use of Bed Rails form dated 6/8/2021 which revealed bed rails were not indicated at that time. The Medical Record did not contain a signed consent for the use of bed rails. A review of a quarterly Minimum Data Set (MDS) dated 8/9/2024 revealed Resident #45 was severely cognitively impaired and had no behaviors. Bed rails were coded as not used for Resident #45. An observation was conducted on 8/20/2024 at 8:18 am of Resident #45. Resident #45 was observed lying in bed with bilateral upper quarter	F 700	Kardex. Beginning on 09/09/24, a communication form will be utilized for resident room moves. This will be initiated by the Social Services Director (SSD). This form will then go to housekeeping staff to ensure that the bed rails will be in place in the new room, if not, then housekeeping and/or social services and/or nursing will notify maintenance. Maintenance will either apply the bed rails or remove them from new bed as necessary. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON and/or SDC, unit manager, MDS coordinator, unit nurse will complete an audit of newly admitted residents and residents that have moved rooms, to ensure that bed rails are in place or not as appropriate. The audit will include the Physicians order, the initial bed rail assessment, quarterly assessment assignment, signed consent, care plan updated, and Kardex updated. Any omission identified in the audit will warrant re-education by the DON and /or SDC/Unit Manager/MDS on non-compliance. The audit will be completed 5 times a week for 4 weeks, 3 times a week for 4 weeks, and 1 time per week for 4 weeks. The DON and/or ED will present monthly for three (3) months, the results of the	

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F 700	Continued From page 15 bed rails raised. An interview was conducted on 8/20/2024 at 8:48 am with Nurse #2. Nurse #2 stated an evaluation for the use of bedrails was performed on admission. Nurse #2 stated bedrails were utilized for mobility purposes or at the request of the resident or resident's family. Nurse #2 stated if a resident required bedrails, there was a quarterly bed rail assessment that had to be completed. Nurse #2 stated there was no evaluation for bed rails in the medical record that indicated Resident #45 needed bed rails, there was no quarterly bed rail assessment, and there was no mention of bed rails in the care plan. Nurse #2 was unsure why there were quarter bed rails used on Resident #45's bed and stated there should not have been. An interview was conducted on 8/20/2024 at 3:42 pm with the Director of Nursing (DON). The DON stated when a resident was admitted to the facility there was an initial assessment for the use of bed rails that was completed by the nurse. The DON stated some residents and/or resident families would request the use of bed rails and signed consent for use. The DON stated if bed rails were used for a resident there should have also been a quarterly assessment for bed rails completed. The DON was unsure why Resident #45 had quarter bed rails on his bed and stated he should not have had bed rails.	F 700	audits and education as indicated to the facility Performance Improvement Committee.(QAPI) This committee consisting of the ED, DON, Medical Director, Director of Maintenance, Director of Rehab, HIM Director, Director of Food and Nutrition Services, Director of Social Services, Business Office Manager, Director of Admissions, and Activities Director will review the findings and make recommendations and develop a plan of action should any areas are noted to be in non-compliance. 5. Date of Completion: 09/12/2024	