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	345195	A. BUILDING _____ B. WING _____	C 03/13/2025

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EDGECOMBE HEALTH CENTER BY HARBORVIEW	1000 WESTERN BOULEVARD TARBORO, NC 27886

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/10/25 through 3/13/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #O4FU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/10/25 through 3/13/25. Event ID# O4FU11. The following intakes were investigated NC00227903, NC00220913, NC00222411, NC00225164, NC00227192, NC00226978, NC00227960 and NC00225981. 19 of the 19 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		4/4/25

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

Electronically Signed | 03/27/2025

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident responsible party (RP) and staff interviews, the facility failed to include documentation in the medical record that the facility staff had spoken with the responsible party (RP) or resident regarding advance directives (Resident #110). This was for 1 of 5 residents reviewed for advance directive. The findings included: A review of the facility's policy titled "Residents' rights Regarding Treatment and Advance Directives" dated 3/1/22 and reviewed/revised on 3/1/24 revealed "it is the policy of this facility to support and facilitate a residents' right to formulate an advance directive. On admission the facility will determine if the resident has	F 578	Resident #110 was admitted on 1/19/23 and remains a resident. On 3/26/25 education regarding formulation of an advanced directive and/or an opportunity to formulate an advanced directive was provided to the representative for review by the Social Worker. All residents have the potential to be affected. On 3/26/25 the Director of Social Work began an audit of all residents to determine the existence of advanced directives in the electronic medical record. For residents with no advanced directives on file, the Director of Social Work will contact the resident, and/or resident	

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F 578	Continued From page 2 executed an advance directive, and if not determine whether the resident would like to formulate an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff." Resident #110's medical record revealed Resident #110 was admitted to the facility on 01/19/23 with diagnoses that included stroke, hypertension, and thyroid disorder. The review also revealed the resident code status was a full code. There was no documentation in the record for education regarding formulation of an advanced directive and/or an opportunity to formulate an advance directive was offered. An interview with Resident #110's RP was held in the facility on 3/13/25 at 9:21 AM, at which time he stated, Resident #110 does not have an advanced directive in place. He went on to say a facility employee talked to him about advanced directives, but he was not interested at that time. He did not recall who spoke with him regarding advanced directives. An interview was completed on 3/13/25 at 8:48 AM with the facility Admission Director. She revealed she does not discuss advance directives with residents or responsible parties (RP) as that task would be the responsibility of the Admissions Nurse. An interview with the Admission Nurse was held on 3/13/25 at 9:05 AM, she stated she speaks to code status only as the Social Worker was responsible for discussing advance directives with residents and their RP.	F 578	representative, to provide information about advanced directives, collect any advanced directives the resident may have, and incorporate any advanced directives into the medical record. Audit will be completed by 3/28/25. On 3/24/25, the Administrator provided an in-service to the Admissions Staff, the Admission Nurses, and Social Work team to review the process for informing new admissions about Advance Directives. All new staff in these roles will be provided with this education during their orientation. On 3/24/25 the facility confirmed it had expanded its electronic Admission Packet to include an acknowledgement of the provision of Advance Directive information at the time of admission. Social Workers are to review Advance Directive information at the initial care conference, and at quarterly care conferences. Any resident advance directives are to be collected by Social Work for processing into the medical record. Beginning on 3/28/25, The Administrator will monitor all new admissions weekly once per week for four weeks, then once every other week for two months, to ensure full compliance with advance directives. The Administrator will review the results from the monitoring and present findings to the monthly QAPI Committee for three	

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F 578	Continued From page 3 An interview with the Social Worker was held on 3/13/25 at 9:45 AM in which she stated typically the Admissions Director would be responsible for the advance directive discussion with residents and RPs. She would not have addressed advanced directives unless a coworker asked her to do so. An interview was completed with the facility Administrator on 3/13/25 at 9:55 AM. At that time, she revealed her expectation would have been that the Social Worker follows up with families that did not have advance directives in place upon admission to educate them and offer assistance and education to establish advance directives if desired. She went on to further state her expectation would have also been that the Social Worker document those conversations in the resident's chart.	F 578	months. Next QAPI meeting is scheduled for 4/3/25. Corrective action completion date: 4/4/25	
F 582 SS=D	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.	F 582		4/4/25

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F 582	Continued From page 4 §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 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 and Responsible Party (RP) interviews, the facility failed to provide a Centers for Medicare and	F 582	Resident #129 was discharged from the facility on 3/12/25.	

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F 582	Continued From page 5 Medicaid (CMS) Form 10123-Notice of Medicare Non-Coverage (NOMNC) within the required time frame. This was for 1 of 4 residents (Resident #129) reviewed for Beneficiary Notices. Findings included: Resident #129 was admitted to the facility on 2/1/25. Review of Resident #129's NOMNC form revealed the effective date coverage of his current skilled nursing and therapy services service would end was 3/11/25. It further revealed Medicare would probably not pay for his skilled nursing and therapy services after that effective date, and Resident #129 might have to pay for any services he received. The form included Resident #129's rights to appeal the decision. It was dated as signed by Resident #129's RP on 3/12/25. On 3/12/25 at 9:43 AM an interview with the Social Worker (SW) indicated Resident #129 was being discharged from the facility that day. She stated she had multiple conversations with Resident #129's RP throughout Resident #129's stay in the facility regarding his discharge plan. She stated she had not had a chance to provide Resident #129's RP with a NOMNC until 3/12/25. She reported every time she went to provide the form to Resident #129's RP and have it signed, the RP had already left the facility. On 3/12/25 at 10:05 AM an interview with Resident #129's RP indicated she had multiple conversations with the SW regarding Resident #129's discharge from the facility and had caregivers in place for Resident #129 when he	F 582	The facility has determined that all residents covered under Medicare Part A have the potential to be affected. On 3/24/25 the Social Services Director initiated an audit of all residents that experienced a discontinuation of Medicare Part A coverage during the past six months to ensure those residents, and/or their responsible parties, were appropriately provided an Advanced Beneficiary Notice (ABN). Any residents lacking an ABN on file will be provided education on resident rights, including the Advanced Beneficiary Notice (ABN) process, with a copy of the completed form placed in their file. Audit will be completed by 3/28/25. On 3/24/25 the Administrator provided an Inservice on the facility□s ABN Process to the Business Office Manager, Social Services Director, MDS Coordinator, Director of Nursing, and Rehabilitation Program Manager. All future hires to these positions will receive this education during their orientation process. The ABN process, conducted as part of morning meeting, outlines the review of residents on therapy approaching 7 days of the discontinuation of therapy services. It reviews potential skilled service needs and identifies those residents that should be provided with an ABN. Social Work issues ABNs for Part A residents and Medicare B residents, to ensure full compliance. The Director of Social Work will educate the Resident Council on	

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F 582	Continued From page 6 got home. She reported she would have liked to have been informed of her rights regarding Resident #129's discharge from the facility before the day of discharge. On 3/12/25 at 10:46 AM a follow up interview with Resident #129's RP indicated she had just spoken with the Business Office Manager, had all her questions answered, and would proceed with taking Resident #129 home that day. On 3/12/25 at 3:40 PM an interview with the Administrator indicated the SW should have ensured Resident #129's RP was provided with the NOMNC form prior to the day of Resident #129's discharge from the facility.	F 582	resident rights, including the Advanced Beneficiary Notice (ABN) process, at the next Resident Council meeting on 4/11/25. Beginning on 3/28/25, the Administrator will conduct an audit of ten residents whose coverage ended, weekly for four weeks, then every other week for two months to ensure they received Notice of Medicare Non-Coverage (NOMNC) within the required time frame. The Administrator will review the results from the monitoring and present findings to the monthly QAPI Committee for three months. Next QAPI meeting is scheduled for 4/3/25. Corrective action completion date: 4/4/25	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for anticoagulant use, antiplatelet use, and discharge status for 4 of 27 resident assessments reviewed (Resident #109, Resident #138, Resident #80, and Resident #139).	F 641	On 3/27/25 The Minimum Data Set Coordinator (MDS) completed a modification to prior comprehensive assessment for Resident #109 to reflect accurate coding of not receiving an anticoagulant. On 3/27/25 The MDS Coordinator	4/4/25

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F 641	Continued From page 7 Findings included: 1. Resident #109 was admitted to the facility on 9/6/24. Review of Resident #109's MDS assessment dated 12/11/24 revealed the resident was assessed as having received an anticoagulant medication during the lookback period. Review of Resident #109's medication administration record for December 2024 revealed the resident did not take an anticoagulant medication during the lookback period. During an interview on 3/11/25 at 11:24 AM the MDS Coordinator stated Resident #109 was not on an anticoagulant and the MDS dated 12/11/24 was coded incorrectly. During an interview on 3/11/25 at 11:46 AM the Administrator stated MDS assessments should accurately reflect the resident's status. 2. Resident #138 was admitted to the facility on 1/1/25. Review of Resident #138's discharge planning progress note dated 1/9/25 revealed the social worker spoke with the responsible party and resident regarding resident's discharge and discharge planning. Resident #138 was being discharged from her managed care insurance on 1/10/25 and would be discharged home on 1/11/25. Review of Resident #138 discharge minimum data set assessment dated 1/11/25 revealed the	F 641	completed a modification to prior comprehensive assessment for Resident #138 to reflect accurate discharge plan. On 3/27/25 The MDS Coordinator completed a modification to prior comprehensive assessment for Resident #80 to reflect accurate coding of receiving an antiplatelet medication. On 3/27/25 The MDS Coordinator completed a modification to prior comprehensive assessment for Resident #139 to reflect accurate discharge location. All residents have the potential to be affected. MDS completed an audit on 3/26/25 of all residents within the last 6 months that were discharged home from the facility and reviewed all current residents that are on an antiplatelet/anticoagulant to ensure they are coded correctly. Audit will be completed by 3/28/25. On 3/26/25 the Regional Director of Case Mix in serviced facility MDS staff on facility policy Certifying Accuracy of Assessments. All new MDS Staff will be in-serviced by the Staff Development Coordinator during their orientation. Beginning on 3/28/25, the Regional Director of Case Mix will audit coding of discharge location, anticoagulant use, and antiplatelet use on 10 MDS a week for 4 weeks, then 5 per month for 2 months to	

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F 641	Continued From page 8 discharge assessment was coded as an unplanned discharge. During an interview on 3/11/25 at 11:18 AM the MDS Coordinator stated Resident #138 had a planned discharge on 1/11/25 and it was coded incorrectly on the 1/11/25 discharge MDS. During an interview on 3/11/25 at 11:46 AM the Administrator stated MDS assessments should accurately reflect the resident's status. 3. Resident #80 was admitted to the facility on 3/14/23. A review of Resident #80's physician's orders revealed an order dated 1/3/25 for aspirin (an antiplatelet medication) 81 milligrams (mg) one tablet by mouth daily for transient ischemic attack (disrupted blood flow to the brain), venous insufficiency (impaired blood flow in the veins), and atrial fibrillation (an irregular heartbeat). A review of Resident #80's February 2025 Medication Administration Record (MAR) revealed documentation aspirin 81 mg was administered to Resident #80 on 2/27/25 and 2/28/25. A review of Resident #80's March 2025 MAR revealed documentation aspirin 81 mg was administered to Resident #80 on 3/1/25 through 3/5/25. A review of Resident #80's quarterly Minimum Data Set (MDS) assessment dated 3/5/25 revealed she was not coded as taking any antiplatelet medications. On 3/13/25 at 8:22 AM an interview with the MDS Coordinator indicated she coded the medication	F 641	ensure accuracy. Any deficiencies found with the Audits will be corrected immediately and reeducation done as necessary by the Administrator. The Administrator will review the results from the monitoring and discuss Audit results in the QAPI meeting monthly for 3 months. Next QAPI meeting is scheduled for 4/3/25.	

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F 641	Continued From page 9	F 641		

section of Resident #80's MDS assessment dated 3/5/25. She stated she did not code Resident #80 as taking antiplatelet medication on this MDS assessment because she had been instructed not to code aspirin as an antiplatelet medication unless the dosage was 325 mg.

On 3/13/25 at 10:18 AM an interview with the Director of Nursing indicated the MDS Coordinator would know more about the coding of MDS assessments than she did. She stated MDS assessments should be an accurate reflection of the medications a resident was taking.

On 3/13/25 at 10:23 AM an interview with the Administrator indicated MDS assessments should be coded accurately.

4. Resident #139 was admitted to the facility on 12/18/24.

The discharge Minimum Data Set (MDS) assessment dated 1/22/25 revealed Resident #139 was discharged to a short-term general hospital.

A progress note written by the Social Worker on 1/22/25 at 2:44 PM stated Resident #139 was discharged from the facility at 12:45 PM and was transported home by his friend.

During an interview with the MDS Coordinator on 3/12/25 at 1:15 PM, she stated the MDS should have been coded to home and her coding was an error.

An interview with the Director of Nursing was held on 3/12/25 at 1:23 PM, at that time she stated the resident was discharged home.

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F 641	Continued From page 10 During an interview on 3/12/25 at 1:26 PM, the Administrator stated her expectation would have been the MDS information was coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		4/4/25

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F 656	Continued From page 11 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to develop an individualized, person-centered comprehensive care plan to include the use of side rails (Resident #82 and Resident #119) and an anticoagulant (blood thinning) medication (Resident #129). This was for 3 of 27 residents whose comprehensive care plans were reviewed. Findings included: 1. Resident #82 was admitted to the facility on 7/31/24 with diagnoses including history of cerebral infarction (stroke). A review of Resident #82's record revealed an assessment titled "side rail/entrapment risk evaluation" dated 2/22/25 and completed by Nurse #1 revealed bilateral one quarter length side rails were to be used. A quarterly Minimum Data Set (MDS) dated 2/28/25 revealed Resident #82 was cognitively intact. The MDS indicated Resident #82 required partial to moderate assistance with bed mobility,	F 656	Resident #82 care plan was updated to accurately reflect side rails Resident #119 care plan was updated to accurately reflect side rails Resident #129 discharged on 3/12/25 All residents in the facility have the potential to be affected. MDS Coordinator completed an audit of all residents on anticoagulant therapy and all residents with siderails ensure the correct diagnosis is reflected and proper interventions are addressed on the care plan. This audit will be completed by 3/28/25. Regional Director of Case Mix in serviced MDS department on how to develop an individualized, person-centered comprehensive care plan to include the use of side rails and an anticoagulant (blood thinning) medication on 3/26/25. Beginning on 3/28/25, as part of clinical startup the Director of Nursing or	

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F 656	Continued From page 12 transfers, and was non-ambulatory. The MDS revealed Resident #82 had impairment of one side of upper extremities and impairment of both lower extremities. The MDS indicated Resident #82's siderails were not used as a restraint. A care plan with the latest review date of 3/3/25 revealed no reference to use of side rails for Resident #82. An observation on 3/10/25 at 11:54 AM revealed Resident #82 lying in bed with bilateral one-quarter length side rails in the up position on the bed. An interview with the MDS nurse was conducted on 3/13/25 at 9:08 AM. The MDS nurse stated she was responsible for updating care plans with information she received from other departments such as Nursing. The MDS nurse revealed she was not aware side rails needed to be addressed in a resident's care plan. In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated she was not aware side rails needed to be addressed in a resident's care plan. In an interview with the Administrator on 3/12/25 at 1:15 PM she stated she was unaware side rail usage needed to be addressed in a resident's care plan. 2. Resident #119 was admitted to the facility on 4/11/24 with diagnoses that included cerebral infarction (stroke). A review of Resident #119's record revealed an assessment titled "side rail/entrapment risk	F 656	designee will review 5 x weekly for 4 weeks and monthly x2 months, any resident with order changes related to anticoagulant therapy, care plans will be reviewed and updated as indicated. Residents with approval for side rails to be used will also be reviewed and care plans will be updated. Any deficiencies found with the Audits will be corrected immediately and re-education done as necessary by the Regional Director of Case Mix. The Administrator will review the results from the monitoring and discuss Audit results in the QAPI meeting monthly for 3 months. Next QAPI meeting is scheduled for 4/3/25. Corrective action completion date: 4/4/25	

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evaluation" dated 2/7/25 and completed by UM #1 revealed the resident was using bilateral quarter length side rails.

A quarterly Minimum Data Set (MDS) dated 2/27/25 revealed Resident #119 was severely cognitively impaired and was dependent on staff for bed mobility. The MDS indicated Resident #119's siderails were not used as a restraint.

A care plan with the latest review date 1/10/25 revealed no reference to side rail usage for Resident #119.

An observation on 3/11/25 at 1:17 PM revealed Resident #119 lying in bed with bilateral one quarter length side rails in the raised position.

An observation on 3/12/25 at 11:39 AM revealed Resident #119 in bed with the one quarter length side rails in the raised position.

An interview with the MDS nurse was conducted on 3/13/25 at 9:08 AM. The MDS nurse stated she was responsible for updating care plans with information she received from other departments such as Nursing. The MDS nurse revealed she was not aware side rails needed to be addressed in a resident's care plan.

In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated she was not aware side rails needed to be addressed in a resident's care plan.

In an interview with the Administrator on 3/12/25 at 1:15 PM she stated she was unaware side rail usage needed to be addressed in a resident's care plan.

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3. Resident #129 was admitted to the facility on 2/1/25 with a diagnosis of atrial flutter (an irregular heartbeat).

A review of a physician's order for Resident #129 dated 2/1/25 revealed to administer Eliquis (an anticoagulant/blood thinning medication) 5 milligrams (mg) to Resident #129 by mouth twice daily for atrial flutter.

A review of Resident #129's admission Minimum Data Set (MDS) assessment dated 2/7/25 revealed Resident #129 was taking anticoagulant medication and an indication for the medication was noted.

A review of Resident #129's Medication Administration Record February 2025 (MAR) revealed documentation Eliquis 5mg was administered to Resident #129 as ordered by his physician.

A review of Resident #129's comprehensive care plan dated last revised on 3/5/25 did not reveal a focus area for or address the risk of bleeding related to receiving anticoagulant/blood thinning medication.

On 3/13/25 at 9:23 AM an interview with MDS Coordinator #2 indicated she completed the medication section of Resident #129's admission MDS dated 2/7/25. She stated she coded this section to indicate Resident #129 was taking anticoagulant medication. She reported she would have been responsible for ensuring his comprehensive care plan reflected his use of this medication and she had not. She stated this was an error on her part.

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F 656	Continued From page 15 In an interview on 3/13/25 at 10:18 AM the Director of Nursing stated anticoagulants were high risk medications that required additional safety monitoring. She reported Resident #129's care plan should have reflected his use of the medication so all staff would be aware he was receiving it.	F 656		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident 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 attempt to use alternatives prior to installing side rails for 2 of 3	F 700	Resident #82 and Resident #119 bed rails were removed on 3/21/25 by Maintenance.	4/4/25

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F 700	Continued From page 16 residents (Resident #82 and Resident #119) reviewed for side rails. Findings included: 1. Resident #82 was admitted to the facility on 7/31/24 with diagnoses including seizure disorder and history of cerebral infarction (stroke). A review of Resident #82's record revealed an assessment titled "side rail/entrapment risk evaluation" dated 2/22/25 and completed by Nurse #1 revealed there was no question on the evaluation regarding attempts to use alternatives before using side rails. Nurse #1 was not able to be reached for interview. A quarterly Minimum Data Set (MDS) dated 2/28/25 revealed Resident #82 was cognitively intact. The MDS indicated Resident #82 required partial to moderate assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #82 had impairment of one side of upper extremities and impairment of both lower extremities. The MDS indicated Resident #82's siderails were not used as a restraint. A care plan with the latest review date of 3/3/25 revealed no reference to use of side rails for Resident #82. An observation on 3/10/25 at 11:54 AM revealed Resident #82 lying in bed with bilateral one-quarter length side rails in the up position on the bed. An observation on 3/12/25 at 11:40 AM revealed Resident #82 sitting in his bed with the head	F 700	All residents who have bed rails have the potential to be affected. On 3/26/25 the DON and Nursing Managers conducted an audit of all residents' beds to ensure that any beds with side rails have appropriate documentation of tried and failed alternatives. The Maintenance Director will remove side rails that do not meet the criteria with appropriate documentation/failed alternatives under direction of DON. The Director of Nursing will ensure that any resident beds that have bed rails after 3/28/25 have proper documentation of failed attempts to provide alternatives to bed rails to meet the resident's needs. The DON and/or Staff Development Coordinator will in-service Nursing Staff (Nurses, CMA, CNA's) on the Proper Use of Bed Rails policy and the importance of ensuring that alternatives are attempted and documentation of the alternatives failure to meet the residents needs prior to installation of Bed Rails by 4/4/25. All new Nursing Staff will be in serviced by the Staff Development Coordinator during their orientation. Beginning on 3/28/25, the DON/Designee will complete Side Rail Audits on 5 new/re-admissions weekly x4 weeks, then monthly for 2 months, to ensure complete documentation. Any deficiencies found with the Audits will be corrected immediately and reeducation	

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F 700	Continued From page 17 raised at a 45-degree angle. The side rails were observed to be in the raised position. An interview with Unit Manager (UM) #1 on 3/11/25 at 2:02 PM revealed the Unit Managers completed the quarterly side rail/entrapment risk evaluations. UM #1 stated they did not attempt alternatives before using side rails. She further stated she was unaware this was a requirement. In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated they did not try interventions before using side rails as she was not aware this was a requirement. In an interview with the Administrator on 3/12/25 at 1:15 PM she stated alternative interventions to side rails were not tried before implementation as she was unaware that this was a requirement. 2. Resident #119 was admitted to the facility on 4/11/24 with diagnoses that included cerebral infarction (stroke). A review of Resident #119's record revealed an assessment titled "side rail/entrapment risk evaluation" dated 2/7/25 and completed by UM #1 revealed no questions regarding attempting alternatives to side rails before implementing them. A quarterly Minimum Data Set (MDS) dated 2/27/25 revealed Resident #119 was severely cognitively impaired and was dependent on staff for bed mobility. The MDS indicated Resident #119's siderails were not used as a restraint. A care plan with the latest review date 1/10/25 revealed no reference to side rail usage for	F 700	done as necessary by the DON. The Administrator will review the results from the monitoring and discuss Audit results in the QAPI meeting monthly for 3 months. Next QAPI meeting is scheduled for 4/3/25. Corrective action completion date: 4/4/2025	

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F 700	Continued From page 18 Resident #119. An observation on 3/11/25 at 1:17 PM revealed Resident #119 lying in bed with bilateral one quarter length side rails in the raised position. An observation on 3/12/25 at 11:39 AM revealed Resident #119 in bed with the one quarter length side rails in the raised position. An interview with Unit Manager (UM) #1 on 3/11/25 at 2:02 PM revealed the Unit Managers completed the quarterly side rail/entrapment risk evaluations. UM #1 stated she completed the quarterly evaluation on 2/27/25 for Resident #119. She further stated they did not attempt alternatives before using side rails. She further stated she was unaware this was a requirement. In an interview with the Director of Nursing (DON) on 3/13/25 at 9:16 AM she stated they did not try interventions before using side rails as she was not aware this was a requirement. In an interview with the Administrator on 3/12/25 at 1:15 PM she stated alternative interventions to side rails were not tried before implementation as she was unaware that this was a requirement.	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		4/4/25

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F 757	Continued From page 19 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a baseline thyroid function test for a resident who was taking Levothyroxine Sodium for 1 of 5 residents reviewed for unnecessary medications (Resident #123). Findings included: Resident #123 was admitted to the facility on 11/1/24. Her active diagnoses included hypothyroidism. Review of Resident #123's physician order dated 11/1/24 revealed the resident was ordered Levothyroxine Sodium oral tablet 25 micrograms, give 1 tablet by mouth in the morning for hypothyroidism. Review of a consultant pharmacist recommendation to the physician dated 11/26/24 revealed the pharmacist recommended a baseline thyroid function test to be completed and	F 757	On 3/13/25 DON notified that lab scheduled for resident #123 on was not drawn on 11/18/24 and 12/18/24. Facility determined lab booked was not checked on either day. On 3/13/25 the DON spoke with resident #123 physician about the missing lab. The physician gave no order to draw lab at that time, physician stated lab would be drawn at next scheduled routine labs. No further orders given. The facility has determined that all residents have the potential to be affected. The Director of Nursing/Designee completed an audit of the last 6 months of scheduled labs to ensure that they have been obtained and resulted to the physician as scheduled. Audit will be completed by 3/31/25. On 3/28/25 in-service initiated for All Licensed Nursing staff by the Staff	

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F 757	Continued From page 20 repeated yearly while Resident #123 was taking Levothyroxine Sodium. The nurse practitioner wrote an order to obtain the lab as recommended. Review of a consultant pharmacist recommendation to nursing dated 12/18/24 revealed the pharmacist again recommended nursing obtain a baseline thyroid function test for Resident #123 per the order from the previous recommendation on 11/26/24 and place them in Resident #123's medical record. Review of Resident #123's medical record on 3/13/25 at 9:30 AM revealed Resident #123 did not have any thyroid function test results documented in the medical record. During an interview on 3/13/25 at 9:42 AM the Director of Nursing stated pharmacy recommendations come to her, and she places them in the physician's box to have the physician or designee respond to the recommendation. The baseline thyroid function test for Resident #123 was scheduled for 12/4/24 as a response to the 11/26/24 pharmacy recommendation and subsequent order from the nurse practitioner. It was ordered and placed in the lab book scheduled for 12/4/24. About a month later, the next recommendation on 12/18/24 came to her from pharmacy and she noted Resident #123's lab was not done on 12/4/24 and she did not know why. She rescheduled the lab for 12/23/24 and the appointment was placed in the lab book as well. She stated this lab was also not obtained and she did not know the reason why. She stated she expects labs like these, which are not stat labs, to be obtained within a few days of the order being written. She concluded this lab was missed	F 757	Development Coordinator regarding the facility process for obtaining routine labs to include a process change that pharmacy recommendations will not be signed off as completed by the DON until any recommended labs have been drawn and resulted. All new Nursing Staff will be in serviced by the Staff Development Coordinator during their orientation. Any staff who do not receive the education by 3/31/25 will receive before working their next scheduled shift. Beginning on 3/28/25, The Director of Nursing or designee, will complete random audits 3 times per week weekly x4 weeks and monthly x2 months of lab orders to ensure that all labs are completed and obtained as scheduled. The Administrator will review the results of the monitoring and those results in the QAPI meeting monthly for 3 months. Next QAPI meeting is scheduled for 4/3/25.	

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F 757	Continued From page 21 and she did not know why. During an interview on 3/13/25 at 9:58 AM the Nurse Practitioner stated the turnaround for a routine lab should be 1 to 2 weeks. These were routine labs and there were no current reasons to think the thyroid-stimulating hormone level was off. He concluded there was no negative outcome for Resident #123 for these labs being missed. During an interview on 3/13/25 at 10:21 AM the Administrator stated labs should be completed as ordered.	F 757		