STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365559	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROLLING HILLS REHAB AND CARE CTR	68222 COMMERCIAL DRIVE BRIDGEPORT, OH 43912

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview the facility failed to promote Resident #1's dignity during meals and Resident #51's dignity related to urinary catheter use. This affected one resident (#51) of two residents reviewed for urinary catheters and one resident (#1) observed during meals. The census was 63. Findings include: 1. Medical record review revealed Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. On 03/11/20 at 12:50 P.M., observation revealed Assistant Director of Nursing (ADON) #32 was observed standing next to Resident #1 in the main dining room. ADON #32 was observed standing while feeding the resident his lunch meal. Human Resources #64 and Administrator in Training #80 were observed in the dining room talking with ADON #32 and did not intervene. At the time of the above observation, the Director of Nursing verified the observation and stated staff should be sitting next to the resident when assisting them with meals. 2. Review of Resident #51's medical record revealed [DIAGNOSES REDACTED]. A plan of care initiated 08/28/19 indicated Resident #51 had a Foley catheter related to [MEDICAL CONDITION] and [MEDICAL CONDITION] bladder after a stroke. One of the interventions was to cover the urinary drainage bag for dignity. Resident #51 had physician's orders [REDACTED]. On 03/10/20 at 8:14 A.M., 9:44 A.M., 11:08 A.M. and 2:00 P.M. Resident #51 was observed sitting in a recliner in his room without the urinary catheter bag covered. The clear side of the bag was facing the hallway with the urine clearly visible. On 03/10/20 at 2:03 P.M., Licensed Practical Nurse (LPN) #25 verified the urinary collection bag was not covered and was visible from the hall.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview the facility failed to ensure Minimum Data Set (MDS) 3.0 comprehensive assessments were accurate. This affected 10 residents (#1, #8, #21, #24, #25, #32, #41, #51, #57 and #273) of 25 residents reviewed for comprehensive MDS 3.0 assessments. Findings include: 1. Review of the hospice Patient/Family Informed Consent dated 10/28/19 revealed Resident #1 had chosen to receive hospice services. Medical record review revealed Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #1 had been receiving Hospice services prior to and since being admitted to the facility. Review of the admission MDS assessment dated [DATE] revealed the resident's prognosis did not include a life expectancy of less than six months to live. Review of the discharge return anticipated Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed the resident received Hospice care prior to and since being admitted to the facility, did not have a terminal prognosis of less than six months to live and used an external condom catheter. Review of the Hospice Recertification dated 10/28/19 to 01/23/20 revealed Resident #1 prognosis was for a life expectancy of less than six months if the terminal illness ran its normal course. On 03/11/20 at 11:49 A.M., interview with Registered Nurse (RN) #12 verified the admission MDS assessment was inaccurate for Resident #1's prognosis. In addition, RN #12 verified the discharge return anticipated MDS assessment dated [DATE] were inaccurate for prognosis and the use of an external catheter. 2. Medical record review revealed Resident #41 was admitted on [DATE] with a [DIAGNOSES REDACTED].#41 was continent of bladder and bowel. Review of the Task: Bowel Continence dated 10/03/19 to 10/09/19 revealed the resident was incontinent of bowel on 13 occasions and had no episodes of continence. Review of the Task: Bladder Continence dated 10/03/19 to 10/09/19 revealed Resident #41 had one episode of urinary continence and 15 incontinent episodes. On 03/09/ at 5:50 P.M., interview with RN #12 verified Resident #41's MDS was inaccurate for bowel and bladder continence. 3. Medical record review revealed Resident #57 was admitted on [DATE] with a [DIAGNOSES REDACTED].#57 was discharged back to the facility after a hospitalization due to [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #57 had no [MEDICAL CONDITION] or 'other fractures'. On 03/09/20, 03/10/20 and 03/11/20, Resident #57 was observed smoking a cigarette during scheduled smoke times. On 03/11/20 at 5:32 P.M., interview with RN #12 verified Resident #57's quarterly MDS assessment dated [DATE] was inaccurate for [MEDICAL CONDITION] and 'other fracture' was not documented on the assessment. 4. Medical record review revealed Resident #25 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Physician order [REDACTED]. Review of the Physical Restraint Decision Tree dated 10/23/19 revealed the side rails were used as enabler's to turn and position. Review of the quarterly MDS assessment dated [DATE] revealed side rails were used daily as a restraint for Resident #25. On 03/09/20 at 4:48 P.M., observation revealed one side rail on the right side of Resident #25's bed. On 03/13/20 at 2:00 P.M., interview with RN #100 verified Resident #25's side rail was not a restraint and the MDS assessment had been coded in error. 5. Review of Resident #21's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed the facility failed to code the antidepressant on the MDS. This was verified during interview with the Director of Nursing on 03/12/20 at 10:30 A.M. 6. Review of Resident #51's medical record revealed [DIAGNOSES REDACTED]. A nursing note dated 08/14/19 at 11:53 P.M. indicated Resident #51 rolled out of bed with no injury noted. Review of an annual MDS assessment dated [DATE] indicated Resident #51 did not have any falls since re-entry or the prior assessment. On 03/12/20 at 1:10 P.M., RN #12 verified Resident #51's annual MDS dated [DATE] was inaccurate regarding falls as it did not capture the fall from 08/14/19. In addition, a physical restraint decision tree assessment dated [DATE] did not indicate the device being evaluated and had no signature. The assessment indicated the device did not restrict freedom of movement. The assessment indicated the device assisted in improvement of Resident #51's functional status and not used to treat medical symptoms. The assessment indicated the device was requested by Resident #51 and his power of attorney. an order written [REDACTED]. Staff were to check the enabler bar daily. There was no physical restraint decision tree completed after the enabler bar ordered on [DATE]. A Medicare five day Minimum Data Set (MDS) assessment dated [DATE] indicated a physical restraint of a bed rail was used daily. On 03/09/20 at 6:35 P.M., RN #12 stated none of the side rails/enabler bars used by any of the facility residents were restraints. However, she had coded all of the rails used as restraints on the MDS 3.0 assessments. RN #12 verified the coding was inaccurate since the devices had been assessed and determined not to be restraints. On 03/11/20 at 8:30 A.M., the Director of Nursing (DON) indicated she believed she did the hand-written restraint assessment dated [DATE] instead of the computerized restraint assessment and stated it was an assessment for the enabler bar. The DON verified she determined the enabler bar did not act as a restraint for Resident #51. Although the order for the enabler bar was dated

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 01/22/20, Resident #51 had it since his readmission to the facility 12/24/19. 7. Review of Resident #273's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the January 2020 Medication Administration Record (MAR) revealed Resident #273 was receiving the anticoagulant, Savaysa. Review of the 01/24/20 Minimum Data Set Assessment indicated Resident #273 had not received an anticoagulant. On 0[DATE] at 6:35 P.M., RN #12 was interviewed and stated she did not code the Savaysa because she did not believe it was an anticoagulant. On 03/09/20 at 6:48 P.M., manufacturer information regarding the Savaysa was reviewed with RN #12 who verified the information indicated Savaysa was an anticoagulant. On 03/10/20 at 8:02 A.M., RN #12 stated she reviewed the January MAR and Resident #273 received five days of anticoagulant which should have been coded on the 01/24/20 MDS. 8. Review of Resident #8's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. On 08/05/19, an order was written for an enabler bar to the left side of the bed for turning and repositioning. The enabler bar was to be checked daily. A physical restraint decision tree dated 10/23/19 indicated the enabler bar did not restrict freedom of movement and was used for assistance with turning and repositioning. A quarterly MDS dated [DATE] indicated under the physical restraint section that a bed rail was used daily. On 03/09/20 at 6:35 P.M., RN #12 verified Resident #8's enabler bar was not used as a restraint but as an enabler. RN #12 verified the coding of the side rail as a restraint on the 12/31/19 MDS was inaccurate. 9. Review of Resident #32's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of the physical restraint decision tree dated 01/21/20 revealed the side rails did not restrict the resident's freedom of movement and the device was considered an enabler. Review of the current self care deficit related to [MEDICAL CONDITION] plan of care (initiated 09/20/19) revealed interventions including bilateral side rails to aide in turning and repositioning written 01/23/20. Review of the quarterly MDS dated [DATE] revealed the resident was cognitively intact and required extensive assistance of two staff members with bed mobility, transfers, dressing, toilet use and personal hygiene. Further review revealed the resident used bed rails daily and these were identified as a physical restraint. On 03/09/20 at 6:35 P.M., RN #12 stated none of the side rails/enabler bars used by any of the facility residents were restraints. However, she had coded all of the rails used as restraints on the MDS 3.0 assessments. RN #12 verified the coding was inaccurate since the devices had been assessed and determined not to be restraints. 10. Review of Resident #24's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physical restraint decision tree dated 10/23/19 revealed the resident had a side rail for assistance with turning and repositioning. Review of the physician's orders [REDACTED]. Review of the quarterly MDS dated [DATE] revealed the resident had severe cognitive impairment and required extensive assistance of two staff members with bed mobility, transfers, toilet use and personal hygiene. Lastly, the MDS reflected the resident had a physical restraint by way of side rails used daily. On 03/09/20 at 6:35 P.M., RN #12 stated none of the side rails/enabler bars used by any of the facility residents were restraints. However, she had coded all of the rails used as restraints on the MDS 3.0 assessments. RN #12 verified the coding was inaccurate since the devices had been assessed and determined not to be restraints. Review of the policy titled Electronic Transmission of the MDS revised September 2010 revealed all MDS assessments were to be completed in accordance with current OBRA regulations governing the transmission of MDS data.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to complete required screenings and assessments as required. This affected one resident (#41) of one resident reviewed for Preadmission Screening and Record Review (PASARR). Findings include: Medical record review revealed Resident #41 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the care plan titled At Risk for Behavior Problems related to [MEDICAL CONDITION] disorder revised 02/25/18 revealed to monitor for behaviors. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #41 was not considered by the State to have a serious mental illness and the resident had active [DIAGNOSES REDACTED]. On 03/10/20 at 11:32 A.M. interview with Social Service Director #22 verified a PASARR should have been completed for Resident #41 and as of 03/10/20 there was no evidence this was completed.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure comprehensive care plans were developed for all residents. This affected three residents (#1, #31, and #57) of 25 residents reviewed for care plans. Findings include: 1. Review of the hospice Patient/Family Informed Consent dated 10/28/19 revealed Resident #1 had chosen to receive Hospice services. Medical record review revealed Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident was ordered to continue receiving hospice services. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #1 had been receiving hospice services prior to and since being admitted to the facility. Review of the Hospice Recertification dated 10/28/19 to 01/23/20 revealed Resident #1 continued to receive hospice services while a resident at the facility. On 03/11/20 at 11:49 A.M., interview with Registered Nurse (RN) #12 verified there was no comprehensive care plan developed by the facility regarding hospice services. 2. Medical record review revealed Resident #31 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #31 was cognitively intact for decision-making and was occasionally incontinent of bladder and frequently incontinent of bowel with no toileting programs. Review of the record revealed Resident #31 had episodes of urinary and bowel incontinence. Review of the record revealed no evidence of a urinary or bowel incontinence care plan. On 03/12/20 at 9:51 A.M., interview with the Director of Nursing (DON) verified there was no evidence of a bowel or urinary care plan for Resident #31. 3. Medical record revealed Resident #57 was admitted on [DATE] with [DIAGNOSES REDACTED].#57 was readmitted after a hospitalization on [DATE] with [DIAGNOSES REDACTED]. Review of the hospital Discharge Summary dated 02/04/20 revealed [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #57 was cognitively intact and had a [DIAGNOSES REDACTED]. Review of the record revealed no actual or potential respiratory care plan. On 03/11/20 at 6:34 P.M., interview with the DON verified Resident #57's did not have a respiratory care plan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure Resident #17's care plan was revised. This affected one resident (#17) of five residents reviewed for activities of daily living. Findings include: Review of Resident #17's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the maintenance program related to therapy plan of care initiated 08/09/19 revealed to walk the resident from the bed to the bathroom with one person physical assist, hemi-walker and gait belt twice a day initiated 10/15/19. Review of the physician orders [REDACTED]. Review of the quarterly MDS dated [DATE] revealed the resident was cognitively intact and required extensive assistance of one staff member with bed mobility, transfers, walk in room, walk in corridor, dressing, toilet use and personal hygiene. The resident received physical therapy services during the assessment period. Review of the State tested nursing assistant (STNA) task list revealed a maintenance ambulation program to walk from the bed to the bathroom with one person physical assist, hemi-walker and gait belt twice a day. Further review of the task documentation revealed the resident participated in the program 14 times from 02/21/20 to 03/11/20. Review of the Physical Therapy (PT) discharge summary dated 0[DATE] revealed the resident had demonstrated minimal functional gains during mobility. Discontinue PT due to highest practical level achieved. The resident was scheduled for cardiologist appointment in March due to ongoing pulse rate and lethargy. On 03/11/20 at 7:28 P.M. interview with STNA #38 revealed the resident was on a maintenance ambulation program and would sometimes ambulate in the hallway until she was tired or she would ambulate from her bed to the bathroom. On 03/12/20 at 9:00 A.M. interview with Occupational Therapist #105 revealed the resident was previously on a maintenance ambulation program with nursing prior to therapy being initiated in January. The resident had an inconsistent heart rate with dizziness and, at the time of discharge from physical therapy, a maintenance ambulation program was not recommended to nursing since therapy did not feel it was safe for STNAs to ambulate Resident #17. On 03/12/20 at 10:30 A.M. interview with

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the Director of Nursing (DON) verified the resident had previously experienced episodes of a low heart rate and the physician had adjusted the resident's medications as a result. The DON also verified the resident was discharged from physical therapy on 02/20/20 and did not have a recommendation for a maintenance ambulation program with nursing due to the PT not feeling the resident should be ambulating with the STNA for safety reasons. Lastly, the DON verified the plan of care was not revised to accurately reflect the resident the resident not being safe to ambulate with an STNA due to her cardiac issues.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to complete a discharge recapitulation and summary as required. This affected one resident (#63) of one resident reviewed for discharge. Findings include: Medical record review revealed Resident #63 was admitted on [DATE] and was discharged to home on 01/21/20. Review of the assessment: Discharge Instruction Form dated 01/21/20 revealed the assessment was not comprehensive. There was no evidence the following areas were completed on the assessment: Medicare information, pharmacy, home care, home services, medication education, prevention and disease management education, emergency information, brief medical history, current treatments, scheduled appointments and tests, medication list including name, action, dose, how to take, when to take it or notes were documented. Review of the nursing note dated 01/21/20 revealed resident to discharge at this time, reviewed all instructions with the resident and daughter. They had no questions or concerns and was given the physician office number to follow up with if they had any issues. Review of the record revealed no evidence of a comprehensive recapitulation or discharge summary for Resident #63. On 03/11/20 at 2:57 P.M., interview with the Director of Nursing verified there was no comprehensive discharge recapitulation for Resident #63 stating the facility had just started using a new form and not all parts of the assessment had been completed.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview the facility failed to ensure non-pressure skin impairment was assessed and treated for [REDACTED]. This affected one resident (#8) of three residents reviewed for non-pressure related skin conditions. Findings include: Review of Resident #8's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. A plan of care initiated 05/03/19 indicated Resident #8 was at risk for skin breakdown related to general weakness. An intervention dated 05/16/19 indicated nurses were to be notified of any redness. On 03/09/20 at 2:21 P.M. interview with Resident #8 revealed he had a rash on his legs which scaled and caused itching. Resident #8 stated staff had tried applying lotion without relief. Resident #8 stated staff had mentioned possibly providing medication for itching but he had not heard anything else about it. A weekly skin assessment dated [DATE] revealed there was no red area that remained after 30 minutes of pressure reduction, no rashes, no excessively dry or flaky skin. On 03/11/20 at 11:40 A.M. an interview with Licensed Practical Nurse (LPN) #76 revealed she was not aware of any skin impairment for Resident #8. On 03/11/20 at 11:45 A.M., LPN #76 assessed Resident #8's legs upon request. A red area was noted to the medial aspect of the right lower extremity in the area of the right ankle. LPN #76 told Resident #8 she would have the nurse practitioner look at the area and determine how she wanted to treat it. Resident #8 reported his legs were itching, especially in the area of the reddened skin. A nursing entry dated 03/11/20 at 12:14 P.M. indicated Resident #8 verbalized itching to bilateral lower legs. Scattered dry areas were noted to bilateral lower legs with a large area noted to the right inner ankle. The nurse practitioner examined the area and provided a new order for [MEDICATION NAME] 0.1% cream to bilateral lower legs twice a day for three weeks. On 03/11/20 at 12:45 P.M., State tested Nursing Assistant (STNA) #17 revealed Resident #8 had been complaining a lot about itching and tended to scratch. The red area on his right inner leg had been there for a while now stating she knew it had definitely been there over two weeks. STNA #17 stated she applied lotion to the area in an attempt to provide relief. STNA #17 stated she was told the wound nurse knew about the area so she did not report it.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of the facility fall investigations and interview the facility failed to ensure fall interventions were implemented, failed to ensure staff were knowledgeable regarding a resident's needs and proper use of equipment, and failed to conduct timely thorough investigations into falls. This affected three residents (#8, #14, and #51) of four residents reviewed for accidents. Findings include: 1. Review of Resident #8's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. A care plan initiated 05/03/19 indicated Resident #8 had a self care deficit related to right sided weakness. A care plan initiated 05/03/19 indicated Resident #8 was at risk for falls related to right sided weakness and general weakness. An admission five day Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was able to make himself understood and was able to understand others. The MDS indicated Resident #8 required extensive assist of two or more people for bed mobility. The MDS indicated Resident #8 had no history of falls within the six months prior to admission or since admission. On 05/16/19 an intervention was added to the self care deficit care plan that read: Bed Mobility: (2) assist required. Another area of the care plan initiated 05/16/19 indicated Resident #8 had an activity of daily living self-care performance deficit related to [MEDICAL CONDITION] and impaired balance. An intervention dated 05/16/19 indicated Resident #8 required (extensive assist) by (one) staff member to turn and reposition in bed. On 05/16/19, an intervention was added to the care plan addressing fall risk indicating Resident #8's bed was to be kept in the lowest position. A nursing note dated 07/31/19 at 3:48 A.M. indicated Resident #8 rolled off the left side of the bed while care was being provided. No injuries were noted and Resident #8 did not complain of pain or discomfort. A quarterly MDS dated [DATE] indicated Resident #8 was cognitively intact. Review of the facility fall investigation/summary indicated the resident stated he rolled off the side of the bed while the aide was caring for him. The report indicated the resident stated he usually grabbed the bedside stand to brace himself but didn't on that occasion. The report indicated Resident #8 was receiving assistance by one staff member at the time of the fall. A new intervention was implemented for an enabler bar to the left side of the bed for turning/repositioning. The report indicated no follow up was required. A witness statement signed by Nursing Assistant #130 indicated Resident (not identified) rolled to his left side to assist with care and rolled himself out of bed. On 03/12/20 at 4:25 P.M., Resident #8 was interviewed regarding the fall from the bed. Resident #8 stated before the aide started to give care he asked if she needed to get help because generally two aides went in and one stood on both sides of the bed as he was rolled. Resident #8 stated the aide told him she did not need help and proceeded to roll him and was unable to catch him when he fell from the bed. Resident #8 stated he told people it was his fault because he did not want the aide to get into trouble. On 03/12/20 at 4:25 P.M., Nursing Assistant #130 was interviewed by phone and stated she had not worked at the facility long when Resident #8 fell . Nursing Assistant #130 stated she did not know anything about Resident #8 when she attempted to provide care as she had not observed anybody giving him care during orientation. Nursing Assistant #130 stated she did not know how Resident #8 rolled or did with bed mobility. Nursing Assistant #130 stated Resident #8 rolled himself over and never mentioned that she might need assistance. Observations of Resident #8 on 03/09/20 at 11:26 A.M. and between 2:11 P.M. and 2:21 P.M., on 03/10/20 at 8:27 A.M., 11:10 A.M., and 2:08 P.M., on 03/11/20 at 4:23 A.M., 10:11 A.M., and 11:45 A.M., and on 03/12/20 at 7:34 A.M., 11:34 A.M., 3:23 P.M., and 3:45 P.M. revealed he was lying in bed but the bed was not in the lowest position. On 03/12/20 at 3:45 P.M., State tested Nursing Assistant (STNA) #59 verified Resident #8's bed was not in the lowest position. 2. Review of Resident #51's medical record revealed [DIAGNOSES REDACTED]. Review of a nursing progress note dated 05/04/19 at 11:40 A.M. revealed upon entering Resident #51's room he was noted to be sitting in front of the bathroom sink on the floor. Resident #51 reported he was going to use the commode. No injuries were noted. Review of a fall investigation/summary report for the fall which occurred on 05/04/19 at 11:40 A.M. indicated Resident #51 had a history of [REDACTED]. No interim interventions

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) were documented to prevent further falls. The psychiatrist or his nurse practitioner would be asked to re-evaluate [MEDICAL CONDITION] medication use. Review of a nursing note dated 05/06/19 at 9:34 A.M. indicated the interdisciplinary team reviewed the fall. Resident #51 was to be seen by the psychiatrist during his next visit. There was no evidence of any new interventions put in place pending the psychiatrist's visit. Review of a progress note dated 08/17/19 at 12:15 A.M. revealed a loud noise was heard. Upon entering Resident #51's room, he was found in a sitting position on the floor next to his bed. Resident #51 indicated he was not sure how but he slid off the bed. No injuries were noted. Review of the fall investigation/summary indicated an intervention for the bed to be kept in the lowest position. This was the intervention implemented after a fall on 08/14/19. Review of a nursing note dated 08/19/19 at 9:47 A.M. indicated the interdisciplinary team reviewed the fall from 08/17/19. Resident #51 was on therapy caseload and regaining strength. The determination was made for Resident #51 to continue with therapy and his current plan of care. Review of a nursing note dated 09/22/20 at 1:45 P.M. indicated Resident #51 was observed lying on the floor beside his bed in front of the wheelchair. Resident #51 was unable to recall or state what happened. The note indicated Resident #51 would return to using the geri chair while up in his room unattended. Review of the fall investigation from 09/22/19 did not reveal that staff attempted to determine if Resident #51 was attempting to transfer from the bed to the wheelchair or vice versa. Review of a nursing note dated 09/23/19 at 10:23 A.M. indicated the interdisciplinary team reviewed the fall and therapy was to assist Resident #51 while in the standard wheelchair. A geri chair was to be utilized at all other times. Review of a nursing note dated 10/08/19 at 12:45 A.M. indicated at 12:30 A.M. Resident #51 was heard yelling out and was discovered sliding off the bed. Resident #51 was lowered to the floor. Resident #51 stated he was trying to get up to the bathroom. Resident #51 was re-oriented and reminded nursing would assist with bathroom needs and transfers in and out of bed. Review of a nursing note dated 10/08/19 at 10:02 A.M. indicated the interdisciplinary team reviewed the fall. A new order was obtained for bilateral floor mats while Resident #51 was in bed. Review of a nursing note dated 10/12/19 at 12:15 A.M. indicated Resident #51 was heard yelling for help and was sliding out of bed onto the fall mat. Resident #51 indicated he was trying to pull his covers up. Review of a nursing note dated 10/14/19 at 10:36 A.M. indicated the interdisciplinary team reviewed the fall and determined all current interventions were to be continued. Review of a nursing note dated 11/12/19 at 12:25 P.M. indicated Resident #51 was observed sitting on the floor in front of the recliner chair. Resident #51 indicated he had to use the bathroom. Review of a nursing note dated 11/13/19 at 9:55 A.M. indicated the interdisciplinary team reviewed the fall. Staff were to offer/assist Resident #51 to the restroom every two hours or as needed. Review of a nursing note dated 11/15/19 at 1:50 P.M. indicated Resident #51 was observed sliding himself out of the chair. Staff intervened and lowered Resident #51 to the floor. No injuries were noted. Review of a fall investigation/summary for the fall on 11/15/19 did not reveal which chair Resident #51 was sitting in. A new intervention was implement for Resident #51 to be assisted back to the recliner or bed for safety after meals. During an interview on 03/12/20 starting at 11:30 A.M., the Director of Nursing (DON) verified the fall which occurred on 05/04/19 was not evaluated for root cause or interventions implemented until 05/06/19 and the psychiatrist visited 05/09/19. The DON verified when residents fell it would be beneficial for staff on scene to attempt to determine root cause of the fall and put immediate interventions in place. The DON verified there was not a timely evaluation of the fall on 08/17/19. The fall was reviewed by the interdisciplinary team on 08/19/19. The DON verified the fall investigation was incomplete but she believed Resident #51 was attempting to transfer from the wheelchair to the bed when he fell on [DATE]. The DON verified education or providing Resident #51 with reminders was not necessarily an appropriate intervention due to his dementia and memory impairment. The DON verified the fall from 10/12/19 was not reviewed by the interdisciplinary team until 10/14/19 to determine if interventions needed changed. The DON verified there was no indication which chair Resident #51 was sliding from on 11/15/19. The DON stated she thought Resident #51 was sliding from the wheelchair and that Resident #51 was probably in the wheelchair for meals with therapy. The DON was non-committal regarding whether Resident #51 should have been transferred back to the recliner after the meal before staff observed him sliding out of the chair because there was already an intervention in place for Resident #51 not to be in the wheelchair in his room unsupervised/without therapy. The DON verified the fall investigations for the above noted falls and additional falls were not comprehensive. On 03/12/20 at 11:55 A.M., Occupational Therapist (OT) #105 stated therapy would not have left Resident #51 in the wheelchair unsupervised after meals on 11/15/19. OT #105 verified a more thorough investigation would be more helpful in determining what happened and to guide any further needed interventions. On 03/12/20 at 12:08 P.M., OT #105 stated Resident #51 got a high back wheelchair on 11/06/19 and Resident #51 would have been safe in the chair as long as he was reclined. Therapy had been discontinued as of 11/11/19. Review of the facility Falls-Clinical Protocol, revised September 2012 revealed staff would evaluate and document falls that occurred while the residents were in the facility. For an individual who had fallen, staff were to attempt to define possible causes within 24 hours of the fall. Based on the assessment, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes of falls could not be readily identified or corrected, staff would try various relevant interventions, based on assessment of the nature or category of falling until falling reduced or stopped or a reason was identified for its continuation. 3. Review of Resident #14's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Morse Fall scale dated 12/30/19 revealed the resident was a high risk for falling. Review of the admission MDS 3.0 assessment, dated 01/04/20 revealed the resident had moderate cognitive impairment and required extensive assistance of two staff members with bed mobility, transfers, and toilet use. The resident also required extensive assistance of one staff member with personal hygiene. Review of the fall investigation dated 01/07/20 revealed on 01/07/20 at 3:35 P.M. the resident was being transferred to the toilet by staff using the sit-to-stand lift and had to be lowered to the floor. The resident was assessed for injuries and a scabbed area to his right knee had been re-opened. The resident denied pain or hitting his head. The resident stated his knees just wouldn't hold up. STNA #42 stated the resident let go of the handles and his knee gave out so she lowered him to the floor. The new interventions were the hoyer lift for all transfers and one to one education for STNA #42 regarding the sit-to-stand-lift. The investigation did not indicate concerns related to the staff not using the lift as the manufacturer intended or any concerns with user error. The investigation did not indicate the lift was inspected for functionality after the incident. Review of the fall response assessment form 2.5 dated 01/07/20 revealed gait disturbance may have contributed to the fall and a pain management assessment had been attempted and the use of a mechanical/hoyer lift was the new intervention added. On 03/11/20 at 2:26 P.M. interview with STNA #42 revealed she was transferring the resident from the toilet when the resident's leg buckled or the lift came undone and the resident began to slide out of the lift so she lowered the resident to the floor and got the nurse. The STNA stated she had been educated, when she was hired, regarding the use of the sit-to-stand lift. On 03/11/20 at 2:52 P.M. interview with LPN #71 revealed she was working the day the resident came out of the lift and he bumped a scab off of his knee. The resident did not have other injuries but she did provide the STNA with one to one education regarding the use of the lift and ensuring the resident was properly secured in the lift. On 03/11/20 at 3:15 P.M. interview with the DON verified the investigation did not determine the root cause of the resident's fall and was not a comprehensive fall investigation. On 03/11/20 at 3:30 P.M. interview with the Administrator revealed the fall was determined to be user error and was not due to faulty equipment. On 03/11/20 at 5:30 P.M. interview with the DON revealed she determined the root cause of the fall to be user error and not faulty equipment when the STNA failed to properly secured the resident's legs with the leg strap provided on the lift. Further interview with the DON verified the staff member was State tested within the last six months and the STNA should have ensured the resident was properly placed in the lift and everything was attached/secured. The DON verified this was part of the orientation. An additional interview on 03/12/20 at 9:30 A.M. revealed the STNA involved was the only staff member educated on the use of lifts after the incident. The lift was used incorrectly resulting in a resident fall. Review of the Clinical Protocol for Falls dated 2001 revealed within 24 hours of the fall, staff will attempt to define the cause of the fall. Review of STNA #42's employee file revealed she received general facility orientation, including fall prevention, on 05/28/19. Further review of the employee file revealed attachment 5, lift program skills check off sheet, stand assist mechanical lifts (Sara 3000) was completed on 05/28/19 and included assisting the resident in placing their feet on the platform of the lift. The STNA also received additional education regarding fall prevention, how serious resident falls could be, what conditions make resident falls more likely to occur and prevention procedures on 08/23/19. Review of the instructions for use of the Sara 3000 sit-to-stand lift revised 04/20/19 revealed to avoid injury, always read the instructions for use and accompanied documents before using the product. An assessment must be made for each individual resident being raised by the lift- by a medically qualified person- as to whether the resident required the

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	365559	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROLLING HILLS REHAB AND CARE CTR	68222 COMMERCIAL DRIVE BRIDGEPORT, OH 43912

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) lower leg straps when using the standing sling and use if necessary.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review and interview the facility failed to implement interventions to restore and/or maintain bowel and bladder continence. This affected one resident (#31) of two residents reviewed for bladder and bowel incontinence. The facility identified no current residents on a bowel and/or urinary toileting program. Findings include: Medical record review revealed Resident #31 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #31 was always continent of bowel and bladder with no toileting program. Review of the quarterly MDS assessment dated [DATE] revealed Resident #31 was occasionally incontinent of bladder and frequently incontinent of bowel with no toileting program. Review of the medical record revealed no evidence of a urinary or bowel incontinence assessment or care plan. Review of the Task: Urinary Continence dated 02/12/20 to 03/12/20 revealed five episodes of incontinence. Further review of the five incontinent episodes revealed Resident #31 was incontinent at 12:32 P.M., 12:56 P.M., 2:17 P.M., 10:30 P.M. and 10:38 P.M There was no evidence in the medical record of intervention to restore or maintain bladder function. Review of the Task: Bowel Continence dated 02/12/20 to 03/12/20 revealed eight episodes of incontinence. Further review of the eight episodes revealed Resident #31 was incontinent at 6:19 A.M., 4:39 P.M., 8:15 P.M., 8:56 P.M., 9:10 P.M., 9:22 P.M., 10:29 P.M. and 10:36 P.M There was no evidence in the medical record of intervention to restore or maintain bladder function. On 03/10/20 at 9:56 A.M., interview with Resident #31 revealed he had problems with his bowel and bladder including episodes of incontinence and constipation. On 03/12/20 at 11:14 A.M., interview with Registered Nurse (RN) #12 verified there was no evidence of an assessment or care plan for Resident #31's bowel or bladder incontinence. RN #12 further verified there were no interventions implemented to restore normal bowel/bladder function for the resident or to decrease the episodes of incontinence. Review of the policy titled Behavioral Programs and Toileting Plans for Urinary Incontinence revised October 2010 revealed guidelines for the initiation and monitoring of behavioral interventions and/or a toileting plan for the resident with urinary incontinence. Options for managing urinary incontinence include primarily behavioral programs, toileting plans and medication therapy.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview the facility failed to ensure residents were assessed for risk of entrapment from bed rails prior to installation and failed to document a review of the risk verses benefits of bed rails with residents or resident representatives. This affected two residents (#8 and #51) of four residents reviewed for accidents. Findings include: 1. Review of Resident #8's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. On 08/05/19 an order was written for an enabler bar to the left side of the bed for turning and repositioning. The enabler bar was to be checked daily. There was no evidence the risks and benefits were explained in order to obtain an informed consent for the bed rail use. There was no evidence of a risk for entrapment being performed prior to the bed rail installation. On 03/10/20 at 11:10 A.M., Resident #8 was observed lying in bed with a bed rails on the left side of the bed. Registered Nurse (RN) #8 confirmed Resident #8 had a bed rail on the left side of the bed with the width between the inner bars of the bed rail measuring 17 and 3/4 inches. Resident #8's trunk was leaning toward the left side. On 03/10/20 at 2:53 P.M., the Director of Nursing (DON) was questioned about what interventions were attempted prior to the use of the assist rails, if there had been an assessment regarding entrapment risk before installation, and if an explanation regarding the risks and benefits of the bed rail use was provided to obtain informed consent prior to use. On 03/11/20 at 10:39 A.M., the DON stated she could find no evidence of education of risk verses benefits for the bed rail use. The DON did not provide any assessments regarding risk of entrapment or other interventions attempted before side rail used. 2. Review of Resident #51's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. an order written [REDACTED]. Staff were to check the enabler bar daily. There was no evidence the risks and benefits were explained in order to obtain an informed consent for the bed rail use. There was no evidence of a risk for entrapment being performed prior to the bed rail installation. On 03/10/20 at 11:45 A.M., observations of the bed assist handle on the right side of Resident #51's bed with the DON revealed the distance between the inner rails was 18 inches. The distance from the frame to the lower part of the horizontal bar was 11.5 inches and the distance between the mattress and the top of the lower part of the horizontal bar was 8.5 to 9 inches depending on the area of the mattress measured. The DON verified with Resident #51's weight the distance between the mattress and bar could fluctuate. On 03/10/20 at 2:53 P.M., the Director of Nursing (DON) was questioned about what interventions were attempted prior to the use of the assist rails, if there had been an assessment regarding entrapment risk before installation, and if an explanation regarding the risks and benefits of the bed rail use was provided to obtain informed consent prior to use. On 03/11/20 at 10:39 A.M., the DON stated she could find no evidence of education of risk verses benefits for the bed rail use. The DON did not provide any assessments regarding risk of entrapment or other interventions attempted before side rail used.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, medication reference review and interview the facility failed to ensure Resident #17 was monitored prior to medication administration known to affect resident heart rate to ensure the medication was justified and necessary. This affected one resident (#17) of six residents reviewed for unnecessary medication use. Findings include: Review of Resident #17's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/08/20 revealed the resident was cognitively intact and required extensive assistance of one staff member with bed mobility, transfers, walk in room, walk in corridor, dressing, toilet use and personal hygiene. Review of the physician's orders [REDACTED]. Due to a low heart rate and complaints of dizziness, the dose was adjusted on 01/15/20. The time of administration was noted on the Medication Administration Record [REDACTED]. daily. Further review of the medical record revealed no parameters for administration or orders to administer the medication if the resident's pulse was lower than recommended. Review of the Davis's Drug Guide for Nurses Fourteenth Edition copyright 2015 revealed adverse reactions/side effects including fatigue, weakness, dizziness, drowsiness and [MEDICAL CONDITION] (low heart rate). Further review revealed to assess apical pulse before administration. If the pulse is less than 50 beats per minute (bpm), withhold medication and notify a health care professional. Review of the resident's vital signs revealed the following heart rates: 01/16/20 9:00 A.M. 41 bpm 01/22/20 9:20 A.M. 48 bpm 02/03/20 10:20 A.M. 49 bpm 02/07/20 12:01 P.M. 45 bpm 02/09/20 9:44 A.M. 44 bpm 02/12/20 10:44 A.M. 45 bpm 02/14/20 8:13 A.M. 43 bpm 02/18/20 9:04 A.M. 44 bpm 03/01/20 6:16 P.M. 48 bpm and 03/07/20 9:06 A.M. 47 bpm No heart rate was noted to be assessed prior to administration of the [MEDICATION NAME]. On 03/12/20 at 1:10 P.M. interview with the Director of Nursing (DON) verified the resident had been having episodes of a low pulse rate with symptoms and the dose of the resident's [MEDICATION NAME] had been adjusted. The DON verified the medication had been administered without assessment of the resident's apical pulse prior and per the drug reference manual the nursing staff had access to on computer desktops indicated the apical pulse should be assessed prior to administration. The DON also verified the medical record did not contain parameters of medication administration related to the [MEDICATION NAME] or when to administer the medication. The DON verified the resident's [MEDICATION NAME] was scheduled for 6:00 A.M.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure palatability of the orange juice. This

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	365559	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) affected one resident (#16) and had the potential to affect all 62 of 62 residents who received food/fluids from the kitchen with the exception of Resident #11 who received nothing by mouth. The facility census was 63. Findings include: Review of Resident #16's medical record revealed [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 was able to be understood and was able to understand others. The MDS indicated Resident #16 was cognitively intact. On 03/10/20 at 2:09 P.M. during an interview with Resident #16 the resident voiced concerns about the facility orange juice. The resident stated when staff provided orange juice from the juice machine it was horrid tasting and separated. Resident #16 stated he had staff buy him good orange juice at a local grocery store and had two staff members taste it then try the facility's juice from the juice machine and they agreed the juice from the juice machine did not taste good, with one of the staff members actually spitting the juice out. On 03/12/20 at 7:41 A.M., Resident #16 stated the problem with the taste of the orange juice had been since before Christmas. On 03/11/20 at 12:27 P.M., temperatures and taste of food on a test tray were monitored. No orange juice was on the test tray so a request was made to taste the orange juice which was served from the juice machine. Dietary Supervisor #61 entered the kitchen and placed orange juice in two cups. After tasting the orange juice, Dietary Supervisor #61 stated the orange juice tasted bland. The surveyor reported upon tasting the orange juice it tasted watery to which Dietary Supervisor #61 nodded her head. Dietary Supervisor #61 stated there had been resident complaints regarding the orange juice from the juice machine.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review and interview the facility failed to ensure food and drinks stored in nourishment refrigerators and personal refrigerators were stored under sanitary conditions. This had the potential to affect all 62 or 62 residents who received food/fluids from the kitchen with the exception of Resident #11 who received nothing by mouth. The facility census was 63. Findings include: 1. On [DATE] at 10:00 A.M., observations of the ,[DATE] hall snack/nourishment refrigerator located in the ,[DATE] hall medication room with Registered Nurse (RN) #8 revealed a bag with a container on top of it. The container was labeled room [ROOM NUMBER] and was dated [DATE] and contained a potato. Inside the bag were two containers with neither container labeled with a name or date. One of the containers had what appeared to be a wilted salad. RN #8 agreed the food in the container appeared to be a wilted salad and disposed of it. The other container had pasta with sauce. RN #8 stated she assumed those containers also belonged to the resident in room [ROOM NUMBER] but could not say with certainty. RN #8 stated night shift nurses were responsible for cleaning the refrigerator and disposing of old food. 2. On [DATE] at 10:07 A.M., observations of the ,[DATE] hall snack/nourishment refrigerator located in the medication room revealed a container of Fritos dip. Licensed Practical Nurse (LPN) #75 stated food was supposed to be disposed of after seven days and stated she knew the dip had been in the refrigerator the week before. There was a bag with spaghetti/bread and a styrofoam carry out container which was not tightly sealed in the refrigerator with no name and no date. This was verified by LPN #75. 3. On [DATE] at 2:28 P.M., RN #8 entered the room with medication and asked Resident #16 if he wanted something to drink to which he replied something to drink would be nice. RN #8 asked if Resident #16 wanted something to drink from the refrigerator to which he responded affirmatively. Resident #16 was offered a choice between Coke and milk. Resident #16 chose milk and RN #8 removed a carton of milk from Resident #16's personal refrigerator, which was expired and sat it on the table in front of him for consumption. RN #8 took the carton and confirmed the date then disposed of it. Review of the facility Foods Brought by Family/Visitors revised [DATE] revealed perishable food brought in by visitors must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers were to be labeled with the resident's name, the item and the use by date. The nursing staff were responsible for discarding perishable foods on or before the use by date. The nursing and/or food service staff were responsible for discarding any foods prepared for the resident that showed obvious signs of potential food borne danger (for example, mold growth, foul odor, past due package expiration dates). Home prepared and home-preserved foods were permitted if brought by family or visitors for individual residents. Such foods could not be shared or distributed to other residents. Review of the facility Refrigerators and Freezers Temperature Logs policy, revised [DATE] indicated the facility would ensure safe refrigerator and freezer maintenance, temperatures and sanitation and would observe food expiration guidelines. On [DATE] at 11:00 A.M., the Director of Nursing (DON) was asked if there was a time frame for how long food brought in from outside could be kept in refrigerators. The DON stated she would have to refer to policies. Upon review of the policies provided by the facility, the DON verified there were no specific time frames. The DON stated she thought food was probably disposed of after two days and nurses should be checking food when checking refrigerator temperatures.
F 0909 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview the facility failed to ensure bed rails were appropriate for use with air mattresses prior to installation. This affected two residents (#8 and #51) of four residents reviewed for accidents. Findings include: 1. Review of Resident #8's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. On 08/05/19, an order was written for an enabler bar to the left side of the bed for turning and repositioning. The enabler bar was to be checked daily. On 08/08/19, an order was written for an alternating pressure mattress. On 03/10/20 at 11:10 A.M., Resident #8 was observed lying in bed with a bed rail on the left side of the bed. Registered Nurse (RN) #8 confirmed Resident #8 had a bed rail on the left side of the bed with the width between the inner bars of the bed rail measuring 17 and 3/4 inches. Resident #8's trunk was leaning toward the left side. There was an alternating pressure mattress on the bed. During a phone interview on 03/10/20 at 1:38 P.M., Drive Medical (manufacturer of the home bed assist handle) Representative #125 indicated the home bed assist handle model #RTL -ADJ was not appropriate to be used on beds with low air loss or alternating air loss mattresses, stating the assist handle could become unsturdy and/or the frame could bend. On 03/10/20 at 2:53 P.M., the DON was informed of the conversation with the Drive Medical representative. The DON revealed she was unaware the bed rail should not be used with an air mattress. 2. Review of Resident #51's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. On 12/24/19, a physician's orders [REDACTED]. an order written [REDACTED]. Staff were to check the enabler bar daily. Review of the Drive Medical Home bed assist handle pamphlet, item #RTL -ADJ, indicated the rail was designed for use on a bed with a box spring and mattress. On 03/10/20 at 11:45 A.M., observations of the bed assist handle on the right side of Resident #51's bed with the Director of Nursing (DON) revealed the distance between the inner rails was 18 inches. The distance from the frame to the lower part of the horizontal bar was 11.5 inches and the distance between the mattress and the top of the lower part of the horizontal bar was 8.5 to 9 inches depending on the area of the mattress measured. The DON verified with Resident #51's weight the distance between the mattress and bar could fluctuate. There was an alternating pressure mattress on the bed. A request was made for the bed rail manufacturer's guidelines. During a phone interview on 03/10/20 at 1:38 P.M., Drive Medical (manufacturer of the home bed assist handle) Representative #125 indicated the home bed assist handle model #RTL -ADJ was not appropriate to be used on beds with low air loss or alternating air loss mattresses, stating the assist handle could become unsturdy and/or the frame could bend. On 03/10/20 at 2:53 P.M., the DON was informed of the conversation with the Drive Medical representative. The DON revealed she was unaware the bed rail should not be used with an air mattress.