STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335373	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAINBRIDGE NURSING & REHABILITATION CENTER	**3518 BAINBRIDGE AVENUE BRONX, NY 10467**

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 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews conducted during the Recertification survey, the facility did not ensure a resident's physical restraint was used for the least amount of time. Specifically, a resident's rear buckle restraint seat belt was not released every 2 hours for 15 minutes for a range of motion and during meals as ordered and periodic re-evaluation of the ongoing need for the restraint was not completed. This was evident for 1 of 2 residents reviewed for Physical Restraints out of a total sample of 38 residents. (Resident #137) The finding is: The facility policy entitled: Physical Restraints, dated 09/20/11, documented that: all residents with restraints will be monitored for continued need, and justification, as needed, arises. Documentation by nursing and physician shall state the medical symptom requiring the need for the restraint and the need for continued use in the CCP and all other relevant documentation. Seatbelts with buckle or Velcro closures that can be self-released by the resident at will are not considered restraints. The resident must be cognitively able to do so and can release the belt at will. Each individual with a restraint must have the restraint released every two (2) hours between fifteen (15) thirty to (30) minutes for the prescribed exercise and activity (e.g., ROM, feeding, hygiene, etc.). The resident's response must be documented appropriately by nursing on an ongoing basis. Restraints will be released at meals and during care. In addition, the clinical record shall include documentation of periodic re-evaluation of the need for the restraints and efforts made to substitute alternate measures. Resident #137 was admitted with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set 3.0 ((MDS) dated [DATE] documented that Resident #137 had severely impaired cognition with short and long-term memory problems. The resident required extensive assistance of 2 staff persons for bed mobility, transfer, and toilet use. On 9/9/2020, from 11:38 AM to 2:27 PM, the resident was observed seated in a reclining wheelchair (w/c) with a rear buckle restraint seat belt in place in their room. The seat belt was not released during this time frame. At 12:24 PM, the resident was observed eating lunch in their room with the seat belt in place. On 9/10/2020, from 11 AM to 2:34 PM, the resident was observed in their room seated in a reclining w/c with the restraint seat belt in place with no release. At 12:30 PM, the Certified Nursing Assistant (CNA#1) was observed entering the residents room with the lunch tray. CNA #1 placed a clothing protector on the resident, placed the meal tray in front of the resident, and exited the room without releasing the seat belt. On 9/11/2020, from 10 AM to 2 PM, the resident was observed in their room seated in a reclining w/c with the seat belt in place. The seat belt was not released during this time frame. At 12:32 PM, CNA #1 entered the room with the resident's lunch tray, placed a clothing protector on the resident, and left without releasing the seat belt. The Comprehensive Care Plan (CCP) Restraint/Seat Belt dated 6/16/2020 documented that the resident was unaware of safety boundaries and had poor trunk and body control. Interventions included releasing the restraint every 2 hours for 15 minutes for range of motion exercise, toileting, ambulation, and at mealtimes. The physician's orders [REDACTED]. The orders documented the seat belt restraint should be released every two (2) hours for 15 minutes for range of motion, toileting, hygiene, nourishment, and mealtimes. The Restraint Initiation/Reduction document dated 4/3/2019 and completed on 4/6/2019 documented that lap buddy removal assessment was done for three days. The resident made numerous attempts to stand and was redirected by staff. The Restraint Initiation/Reduction document dated 4/6/2019 and completed on 4/10/2019 documented that lap buddy removal assessment was done for three days. The resident continues to get out of the chair unassisted needing continuous monitoring. The Restraint Initiation/Reduction document dated 4/10/2019 and completed on 4/14/2019 documented that resident continued to stand up from the chair and was redirected by staff for safety numerous times. The Restraint Initiation/Reduction document dated 2/20/2020 documented that resident is alert and oriented and seatbelt removal trial day 1 to 3 was performed. The resident continues to stand up despite the seatbelt. The Restraint Evaluation Monthly document dated 3/31/2020 documented that resident is alert with confusion with [DIAGNOSES REDACTED]. Continued use and needs Quarterly review. The evaluation further documented the rationale for rear seatbelt restraints was that the resident continued to rock back and forth and attempted to stand and move locked wheelchair. This was discussed with resident legal/designated representative including discussion of risk, benefits and alternatives. The Restraint Removal Assessment and Observation dated 7/29/2020 completed by the RN/Manager documented that the resident continued to require seatbelt daily as per plan of care. Restraint removal unsuccessful. There was no documented evidence that ongoing need for restraint had been re-evaluated periodically between April 2019 and February 2020. The Resident Medication Administration Record (MAR) dated July 2020, August 2020, and September 2020, documented a rear-facing seat belt was in place while in a wheelchair and should be released every 2 hours for 15 minutes for range of motion, toileting, hygiene, nourishment, and mealtimes due to the history of falling. The time frames listed were 7:30 to 3:30 PM, 3:30 PM to 11:30 PM, 11:30 PM to 7:30 AM. There was no documentation on the MAR that seat belt had been released every two (2) hours. The CNA Accountability Records (CNAAR) dated August 2020 and September 2020 contained no documentation regarding the use of the rear buckle restraint seat belt. On 9/10/2020 at 12:38 PM, an interview was conducted with CNA #1. CNA#1 stated that the resident is always strapped with the restraint seat belt at all times, and she did not know when it would be released. The CNA looked at her CNA Accountability instructions and stated there was nothing mentioned regarding when the seat belt should be released. The CNA did not know how often or when the seat belt needed to be released. On 9/10/2020 at 12:50 PM, an interview was conducted with Registered Nurse (RN#1). RN#1 stated that the resident should be released every two hours as per the care plan. RN #1 also stated that when she look at the CNAAR and CNA Documentation History Details there is no task for releasing the resident's seat belt restraints, therefore the CNAs would not know it needed to be done because it is not on their task. RN#1 further stated the only restraint evaluation documents for the resident were completed on 4/6/19, 4/10/2019, 4/14/2019, 2/23/2020 and 3/31/2020 and could not explain why it had not been completed between April 2019 and February 2020. On 9/11/2020 at 12:50 PM, the Registered Nurse (RN#1) was interviewed after observing Resident #137 eating lunch in their room with the rear buckle seat belt restraint in place. RN #1 stated the seat belt should be released during mealtimes and every two hours. On 09/14/2020 at 10:59 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that Resident #137's physician order [REDACTED]. The DON also stated that the resident should be evaluated and assessed every month for the continued use of the restraint. The restraint order for every two hours release can be found on the Medication Administration Record. The DON stated that the restraint release schedule should have been documented on the MAR every two hours under restraint monitoring, not as 7:30 to 3:30 PM, 3:30 PM to 11:30 PM, and 11:30 to 7 30 AM which would only be documentation once per shift. The DON further stated that the CNA's would not know when to release the resident's seatbelt restraint because it is found only in the Medication Administration Record. On 09/14/2020 at 11:28 AM, an interview was conducted with the Attending Physician (AP). The AP stated that the resident had a history of [REDACTED]. The physician ordered the rear buckle seat belt restraint for the resident, and it is to be released every two

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

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

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F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) hours for a range of motion, care, and during mealtime. The AP also stated that the last monthly restraint evaluation was completed on 3/31/2020. The AP further stated the resident was evaluated during this period but he had not completed the monthly restraint evaluation form until 9/12/20. 09/14/2020 at 12:07 PM, an interview was conducted with the Rehabilitation Director (RD). The RD stated that the resident used to have a lap buddy, which was ineffective. The rear buckle seat belt helped prevent the resident from falling. The RD added that during their care plan meetings, it was very clear that the resident had to be released every two hours for a range of motion when receiving care and during meals. The Interdisciplinary Team decided that the resident will have a rear seat belt restraint that should be released every two hours. 415.4(a) (2-7)