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	495370	A. BUILDING _____ B. WING _____	C 10/17/2019

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BRIDGEWATER HOME , INC.	302 NORTH SECOND STREET BRIDGEWATER, VA 22812

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/15/19 through 10/17/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/15/19 through 10/17/19. Two complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 127 certified bed facility was 123 at the time of the survey. The survey sample consisted of 24 current Resident reviews and four closed record reviews.	F 000		
F 641 SS=D	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 observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) regarding dental status for one of 28 residents in the survey sample (Resident #47). The findings include:	F 641	F641 Accuracy of Assessments 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #47 has a scheduled	11/4/19

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

Electronically Signed | 10/31/2019

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F 641	Continued From page 1 Resident #47 was admitted to the facility on 8/30/18 with a re-admission on 9/12/18. Diagnoses for Resident #47 included wrist fracture, gastroesophageal reflux disease, depression, anemia, high blood pressure and history of pulmonary embolism. The MDS dated 8/8/19 assessed Resident #47 as cognitively intact. On 10/15/19 at 12:00 p.m., Resident #47 was interviewed about quality of life in the facility. Resident #47's bottom, front teeth were broken with black/gray discoloration. Several of the lower front teeth were deteriorated down to the gum. The resident's top front teeth were chipped. Resident #47 was interviewed at this time about her teeth. The resident stated she had a partial plate on the top and her front teeth in the plate were chipped. Resident #47 stated her bottom teeth were not in good condition and needed repair. Section L0200 of Resident #47's annual MDS dated 8/8/19 documented the resident had no dental problems. This section documented the resident had no chipped dentures and no obvious or likely cavities or broken teeth. The admission MDS dated 9/6/19 included no assessment of the resident's teeth and documented "unable to examine." On 10/16/19 at 2:08 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about the accuracy of Resident #47's dental assessment on the 8/8/19 MDS. LPN #3 stated the registered dietitian (RD) was responsible for completing section L0200 regarding the resident's dental status. LPN #3 stated the dental section on the 8/8/19 MDS was not accurate as the	F 641	appointment with Community Dental Health on November 19, 2019 for a complete dental assessment. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Clinical Coordinator (CC) team, QAPI Coordinator, Infection Preventionist, and DON met with the RD following the survey finding on 10/23/19 for reviewing Section L; L0200 Dental. It was discussed as a team and agreed upon that Section L; L0200 will be completed by the Clinical Coordinator within each respective household. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not recur; From a logistical perspective, the Clinical Coordinator (CC) will have direct oversight for the accurate completion of Section L; L0200. The RD will no longer have responsibility for conducting the oral health screening for each resident as this will be completed by the CC. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The practice for completing Section L; L0200 will be permanently assigned to the Clinical Coordinator (CC).	

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F 641	Continued From page 2 resident had obvious decay on the lower front teeth. On 10/17/19 at 9:45 a.m., the facility's RD was interviewed about the inaccurate assessment of Resident #47's teeth. The RD stated she completed the dental section by reviewing the nursing notes and conducting interviews with the resident and staff about any eating problems. The RD stated she did not perform an actual examination of the resident's teeth/mouth. The RD stated she had been told to complete section L0200 of the MDS but did not actually feel competent completing the section. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual documents on page L-2 regarding completion of section L0200, "...If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks...Conduct exam of the resident's lips and oral cavity with dentures or partials removed... Check L0200A...if the denture or partial is chipped, cracked...Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 10/17/19 at 10:15 a.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, Centers for Medicare & Medicaid Services, Revised October 2019.	F 641	5. Include date(s) when the corrective action will be completed for each identified deficient practice. This practice will be fully implemented by 10/28/19. Overview of Section L; 0200 regarding additional residents that may be affected by this practice will be completed by 11/4/19.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		11/20/19

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F 688	Continued From page 3 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to ensure a hand positioning device and an arm positioning device were in place for one of 28 residents, Resident #51. Findings included: Resident #51 was originally admitted to the facility on 05/09/1995 and readmitted on 06/03/2013 with diagnoses including, but not limited to: Cerebral Palsy, Seizures, Spastic Quadriplegia, Aphasia, and Legal Blindness. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date of 08/13/2019. Resident #51 was assessed as severely impaired in his short and long term memory and daily decision making	F 688	F-688 Increase/Prevent Decrease in ROM/Mobility; 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #51 will have the ordered positioning devices: stuffed monkey for comfort/contractures and the blue palm grip for contractures applied every AM and removed at HS. This order will be reflected in the Treatment Administration Record (TAR) and monitored daily by the Charge Nurse. 2. Address how the facility will identify other residents having the potential to be	

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F 688	Continued From page 4 skills. Resident #51 was observed on 10/15/2019 at 12:15 p.m. in the living room area, reclined in a Broda chair. No positioning devices were observed. Resident #51's clinical record was reviewed on 10/16/2019 at 9:26 a.m. Included in the comprehensive care plan (CCP) was the following: "...Impaired mobility/ADL [activities of daily living] Deficit related to contractures...I will maintain my strength and ROM [range of motion] as evidenced by participation in my Restorative Care Program...I have a stuffed monkey that provides me with comfort and is also used per restorative PROM [passive range of motion] as a device to help with my contractures. Assisting with positioning my monkey to help with comfort and control of contractures. Blue palm grip to the right hand, Monkey in right hand for positioning. On in morning and off with HS [bedtime] care..." On 10/16/2019 at 10:30 a.m., Resident #51 was observed in the living room area, reclined in a Broda chair. No palm grip or stuffed monkey were in place as positioning devices. Resident #51 was observed again at 3:25 p.m. lying in his bed, again without his palm grip or monkey in place. On 10/16/2019 at 3:30 p.m., Resident #51 was observed with LPN #4 (licensed practical nurse). LPN #4 noted that the positioning devices were not in place. LPN #4 went to the resident's closet and retrieved laminated directions (picture diagrams) for device placement from the closet door. LPN #4 proceeded to place the palm guard into Resident 51's right hand and positioned the	F 688	affected by the same deficient practice; Assistive and positional devices for each resident will be placed in Point of Care and included in the Resident Care Sheets to ensure accuracy of application. The Charge Nurse will include ordered assistive and positional devices in the TAR to ensure application when additional monitoring is required. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not recur; Systemic changes in the process include adding the assistive and positional devices in Point of Care, Resident Care Sheets, and TAR. This will provide a more comprehensive approach to ensure the devices are in place consistently. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The performance of this new process will be monitored weekly (Wednesday's) during our Clinical Coordinator and QAPI meeting. 5. Include date(s) when the corrective action will be completed for each identified deficient practice. This new process will be implemented November 6, 2019 with a completion date of November 20th, 2019.	

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F 688	Continued From page 5 stuffed monkey between his right arm and his side as shown on the directions. LPN #4 was interviewed regarding Resident #51's CNA (certified nursing assistant). LPN #4 stated, "His CNA left at 3:00 p.m. Normally the CNAs place positioning devices. I don't know why his devices weren't placed today." On 0/16/18 at approximately 3:45 pm Other #4 (Occupational Therapist) was interviewed with regarding Resident #51's positioning devices. Other #4 stated, "We made a device to go around his arm to keep his arm from contracting inward at the elbow, but we decided to add more filling to his stuffed monkey and use that instead because he will hold onto it and not remove it." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 10/16/2019 at approximately 4:45 p.m. No further information was received by the survey team prior to the exit conference on 10/17/2019.	F 688		
F 700 SS=E	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	F 700		11/6/19

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F 700	Continued From page 6 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 observation, facility document review, staff interview and clinical record review, the facility staff failed to attempt appropriate alternatives and assess for entrapment risks prior to use of bed rails for four of 28 residents in the survey sample (Residents #10, #23, #37 and #105). Residents #10 and #23 used special mattresses with bed rails without a prior assessment for bed safety. The findings include: 1. Resident #10 was admitted to the facility on 11/21/13 with a re-admission on 8/9/16. Diagnoses for Resident #10 included schizoaffective disorder, bipolar disorder, depression, bladder spasms, anxiety, anemia, sleep apnea, chronic obstructive pulmonary disease, spinal stenosis, macular degeneration, and diabetes. The minimum data set (MDS) dated 7/11/19 assessed Resident #10 with short and long-term memory problems and severely impaired cognitive skills. This MDS listed the resident required the extensive assistance of two people for bed mobility. On 10/15/19 at 12:55 p.m., Resident #10 was	F 700	F-700 Bedrails; 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. A new and appropriately proportioned mattress to accommodate the wider bed frame was placed on resident#10's bed 10/23/19 by maintenance. Followed by a safety check for bed/mattress compliance. An updated Bed Safety Siderail Entrapment Assessment will be completed by 10/30/19. Resident # 23 had a successful safety electrical check for the air mattress pump on 10/25/19. An updated Bed Safety Siderail Entrapment Assessment will be completed by 10/30/19. BRC does not require a physician's order for an air mattress, the air mattress was listed in "point of care" as per our policy. Resident #105 will have an updated Bed Safety Siderail Entrapment Assessment completed by 10/30/19. Resident #37 will have an updated Bed Safety Siderail Entrapment Assessment	

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F 700	Continued From page 7 seated in a Broda chair in the day area. The resident was raising up, attempting to get out of the chair unassisted. On 10/16/19 at 10:00 a.m., Resident #10's bed environment was inspected. The resident's bed had two quarter length side rails in the raised position near the head of the bed. There was a concave shaped mattress on the bed with an approximately 6-inch gap from the end of the mattress to the headboard. There was approximately a 2-inch gap from the bottom of the mattress to the bed's footboard. There was no assessment of bed safety or potential entrapment risks related to use of the concave mattress with the side rails in Resident #10's clinical record. The record documented a physician's order dated 9/5/17 for "2 half side rails @ (at) head of bed to enable self turning and positioning." The most recent side rail assessment dated 11/21/13 listed the resident had no altered safety awareness, no cognitive decline and required the rails to promote independence and mobility. There were no prior attempted alternatives to the rails listed on the assessment or in the clinical record. Resident #10's signed a consent form on 11/21/13 documenting the potential risks for rails had been explained but no risks were identified on the form. The record documented no bed assessment regarding the concave mattress and no other bed rail assessment since 11/21/13. Resident #10's clinical record documented the resident had a history of falls with the resident frequently attempting to get out of her bed and/or chair without assistance. On 7/29/19,Resident	F 700	completed by 10/30/19. Our current Bed Safety Siderail Entrapment Assessment and consent forms will be revised and updated by November 6, 2019 to include verbiage regarding risks associated with the use of siderails and alternatives to siderails when appropriate. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; BRC will implement the newly revised Bed Safety Siderail Entrapment Assessment 11/6/19. This assessment will be required to be completed: Quarterly, A noted significant change in the resident's condition, Anytime the resident's compliment is changed (air mattress, or additional siderail). 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not recur; The systemic change in practice will be reviewed weekly during our Clinical Coordinator and QAPI meetings each Wednesday. If a resident requires changes to their current bed, mattress, rails, etc. Nursing will notify maintenance for further assessment and appropriate placement of the needed items. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;	

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F 700	Continued From page 8 #10's rolled out of bed onto protective floor mats resulting in a skin tear to her right arm and a knee abrasion. The concave mattress was documented in use at the time of this fall. Resident #10's had additional falls from a Broda type chair on 5/28/19, 8/26/19, 10/2/19 and 10/4/19. Resident #10's plan of care (revised 10/11/19) listed the resident was at high risk of falls due to impulsive behaviors, severe cognitive impairment, poor safety awareness, history of falls, visual impairment, auditory hallucinations/delusions and attempts to self-transfer without staff assistance. The plan documented, "I [Resident #10] often make poor/un-safe decisions regarding safe mobility and transfers and do not like staff to try to educate/correct. I have impulsive Behaviors that can be difficult for staff to anticipate or re-direct to safer alternatives..." Interventions listed to prevent falls included, "...assure concave mattress is on bed which is a wider bed, bed in lowest position, with body pillows for positioning and now has (2) mattresses next to bed on floor to prevent injury if Res. [resident] self-transfers OOB [out of bed]..." Two side rails were listed under the resident care summary as an "enabler." On 10/16/19 at 1:48 p.m., the certified nurses' aide (CNA #1) routinely caring for Resident #10 was interviewed. CNA #1 stated the rails and concave mattress had been in place with the resident for an extended time. CNA #1 stated when Resident #10 was awake and alert, she was able to pull or hold the rails when care was performed. CNA #1 stated Resident #10 did not independently use the rails to sit in bed and required help from staff for turning.	F 700	Quarterly reports will be generated via our EMR for QAPI oversight. Our Maintenance Director will receive the generated list to ensure bed inspections are current and accurate for all residents. 5. Include date(s) when the corrective action will be completed for each identified deficient practice. Resident #10's mattress corrected 10/23/19. Resident #23 successful inspection of air mattress pump 10/25/19. Resident #10, #23, # 105, & # 37 will have updated Bed Safety Siderail Entrapment Assessments completed by 11/6/19. Bed Safety Siderail Entrapment Assessment and consent forms will be revised and updated by November 6, 2019 to include verbiage regarding risks associated with the use of siderails and alternatives to siderails when appropriate.	

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F 700	Continued From page 9	F 700		

On 10/16/19 at 1:52 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about bed rail assessments and bed safety. LPN #3 stated bed rail assessments were completed upon admission to see if the resident and/or responsible party wanted the rails. When asked if any re-assessment of the bed rails was completed, LPN #3 stated rails were re-assessed if the interdisciplinary team felt there was a need or if therapy made a recommendation about the rails. When asked about any assessment of Resident #10's bed rail use since 11/21/13, LPN #3 stated she did not see a recent assessment. LPN #3 stated she had no knowledge of any attempted alternatives to the bed rails. LPN #3 stated maintenance installed the concave mattress and was responsible for bed safety checks when mattresses were changed.

On /10/16/19 at 2:47 p.m., the director of nursing (DON) was interviewed about assessments for bed rail safety. The DON stated all the beds in the facility were purchased after 2006 and according to the bed manufacturer, had no entrapment zones. The DON stated a gap measurement device was ordered in case specialty mattresses were used. The DON stated maintenance performed bed safety checks and again stated the beds in use in the facility did not have entrapment risks. The DON presented a letter from the bed manufacturer stating the beds with rails and mattresses were purchased by the facility in 2009.

On 10/16/19 at 4:20 p.m., the maintenance supervisor (other staff #2) was interviewed about bed safety inspections. The maintenance supervisor stated he checked beds/mattresses/rails once per year. The

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F 700	Continued From page 10	F 700		

maintenance director stated they checked to be sure the mattress and bed were in good condition and that the side rails functioned properly. The maintenance director stated he did not perform "gap measurements" because their bed manufacturer informed them they complied with FDA [Food and Drug Administration] bed safety guidelines when the beds were purchased. The maintenance director stated if a specialty mattress was installed, a bed safety check was supposed to be performed.

On 10/16/19 at 4:32 p.m., accompanied by the maintenance supervisor, Resident #10's bed, rails and mattress were inspected. The maintenance supervisor was shown and interviewed about the approximately 6-inch gap between the mattress and the head of the bed. The maintenance supervisor identified Resident #10's bed as bed #60. The maintenance supervisor stated concerning the gap, "Yes. That's a concern." The maintenance supervisor stated a safety check had not been performed on this bed with the concave mattress in place. The maintenance supervisor stated he was not aware the concave mattress had been installed and that Resident #10's bed was a "wide" bed and not the standard resident bed.

The maintenance supervisor presented documented bed inspection records. Bed number 60 was most recently inspected in November 2018 and there was no evidence the concave mattress was in place at the time of the inspection.

On 10/16/19 at 4:54 p.m., the DON was interviewed again about any resident assessment regarding bed rails, the concave mattress or any

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attempted alternatives to the rails. The DON stated Resident #10 started using the concave mattress in May 2019. The DON stated the concave mattress was put in place because the resident was having frequent falls.

These findings were reviewed with the administrator and DON during meetings on 10/16/19 at 4:45 p.m. and 10/17/19 at 10:20 a.m.

2. Resident #23 was admitted to the facility on 12/23/13 with diagnoses that included congestive heart failure, high blood pressure, spinal stenosis, chronic kidney disease, chronic pain, anxiety, tremors, diabetes with neuropathy and anemia. The minimum data set (MDS) dated 7/18/19 assessed Resident #23 with moderately impaired cognitive skills and as requiring extensive assistance of two people for bed mobility.

On 10/15/19 at 3:30 p.m., Resident #23 was in bed. Two quarter length bed rails were in the raised position near the head of the bed. An alternating air mattress was in place on the bed. Resident #23 was observed again on 10/16/19 at 10:00 a.m. and 11:00 a.m. in bed with the air mattress in place with raised bed rails.

Resident #23's clinical record documented no assessment of entrapment risks related to the bed rails with the alternating air mattress or of any prior attempted alternatives to the rails.

Resident #23's clinical record documented a physician's order dated 9/5/17 for "2 side rails @ (at) head of bed to enable self turning and repositioning." The was no physician's order for the air mattress but it was listed as an intervention under "point of care" devices for skin

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protection.

The most recent side rail assessment was dated 12/23/13 and listed the resident had no altered safety awareness, no cognitive decline, had a history of falls and took medications that required increased safety precautions. This form made no mention of any risks associated with the resident's use of bed rails and stated the resident required the rails to promote independence and to provide safety. There were no attempt alternatives to side rails listed on the assessment or in the clinical record. A consent form signed by the resident on 12/23/13 documented the potential risks for rails had been explained but no risks of the rails were identified or listed on the form. The record documented no bed assessment regarding the air mattress and no other bed rail assessment since 12/23/13.

Resident #23's plan of care listed the resident had impaired decision-making, impaired vision and was at risk of falls due to limited mobility, weakness and incontinence. Interventions to prevent falls included, "...side rail use as needed/appropriate. Resident and POA [power of attorney] request use of 2 1/2 upper siderails for safety and to promote turning and positioning..." The plan listed the air mattress as a device intervention to prevent skin breakdown.

On 10/16/19 at 1:46 p.m., the certified nurses' aide (CNA #1) routinely caring for Resident #23 was interviewed. CNA #1 stated when Resident #23 was awake and alert, she was able to pull or hold the rails when care was performed. CNA #1 stated Resident #23 did not independently use the rails to sit up and required help from staff for turning in bed.

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On 10/16/19 at 1:52 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about bed rail assessments and bed safety. LPN #3 stated bed rail assessments were completed upon admission to see if the resident and/or responsible party wanted the rails. LPN #3 stated rails were re-assessed if the interdisciplinary team felt there was a need or if therapy made a recommendation about the rails. When asked about any assessment regarding Resident #23's bed rails use since 12/23/13, LPN #3 stated she did not see a recent assessment. LPN #3 stated she had no knowledge of any attempted alternatives to the bed rails. LPN #3 stated maintenance installed the air mattress and was responsible for bed safety checks when mattresses were changed.

On /10/16/19 at 2:47 p.m., the director of nursing (DON) was interviewed about assessments for bed rail safety. The DON stated all the beds in the facility were purchased after 2006 and according to the bed manufacturer, had no entrapment zones. The DON stated a gap measurement device was ordered in case specialty mattresses were used. The DON stated maintenance performed safety checks on beds/mattresses and again stated the beds in the facility did not have entrapment risks. The DON presented a letter from the bed manufacturer stating the beds with rails and mattresses were purchased by the facility in 2009.

On 10/16/19 at 4:20 p.m., the maintenance supervisor (other staff #2) was interviewed about bed safety inspections. The maintenance supervisor stated he checked beds/mattresses/rails once per year. The

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maintenance director stated they checked to be sure the mattress and bed were in good condition and that the side rails functioned properly. The maintenance director stated he did not perform "gap measurements" because their bed manufacturer informed them they complied with FDA bed safety guidelines when the beds were purchased. The maintenance director stated if a specialty mattress was installed, a bed safety check was supposed to be performed.

On 10/16/19 at 4:32 p.m., accompanied by the maintenance supervisor, Resident #23's bed, rails and mattress were inspected. The maintenance supervisor was interviewed about the air mattress in use on the bed. The maintenance supervisor stated he had not performed a bed inspection with the air mattress in place. The maintenance director stated he was not aware the air mattress was installed on the bed. The maintenance director identified Resident #23's bed and #102.

The maintenance supervisor presented documented bed inspection records. Bed number 102 was most recently inspected in November 2018 and there was no documentation the air mattress was in place at the time of the inspection.

On 10/16/19 at 4:54 p.m., the DON stated Resident #23's air mattress had been in use since February 2019.

These findings were reviewed with the administrator and DON during meetings on 10/16/19 at 4:45 p.m. and 10/17/19 at 10:20 a.m.

3. Resident #105 was admitted to the facility on

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4/1/09 with diagnoses that included cerebral palsy, intellectual disability, high blood pressure, dermatitis and hypertensive retinopathy. The minimum data set (MDS) dated 9/19/19 assessed Resident #105 with moderately impaired cognitive skills and to require the extensive assistance of one person for bed mobility.

On 10/15/19 at 3:30 p.m., Resident #105 was observed in bed with two quarter length bed rails in the raised position near the head of the bed. The resident was observed in bed again with raised side rails on 10/16/19 at 7:53 a.m.

Resident #105's clinical record documented no assessment for entrapment risks related to use of the bed rails and no prior attempted alternatives to the bed rails.

Resident #105's clinical record documented a physician's order dated 4/24/18 for, "2 half side rail @ (at) head of bed to enable self turning and repositioning."

The most recent side rail assessment was dated 4/1/09 and listed the resident had no altered safety awareness, no cognitive decline and no history of falls. This form made no mention of any risks associated with the resident's use of bed rails and stated the resident required the rails to promote independence and to provide safety. There were no attempt alternatives to side rails listed on the assessment or in the clinical record. The resident/family signed a consent form on 1/21/09 documenting the potential risks for the rails had been explained but no risks were identified on the form. The record documented no bed rail assessment since 4/1/09.

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Resident #105's plan of care (revised 9/26/19) listed in the resident care summary that the resident used two-half length side rails at the head of the bed as an "enabler."

On 10/16/19 at 1:45 p.m., the certified nurses' aide (CNA #1) routinely caring for Resident #105 was interviewed. CNA #1 stated the resident was able to use the rails to turn partially in bed.

On 10/16/19 at 1:52 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about bed rail assessments and bed safety. LPN #3 stated bed rail assessments were completed upon admission to see if the resident and/or responsible party wanted the rails. LPN #3 stated rails were re-assessed if the interdisciplinary team felt there was a need or if therapy made a recommendation about the rails. When asked about any assessment regarding Resident #105's bed rails use since 4/1/09, LPN #3 stated she did not see a recent assessment. LPN #3 stated she had no knowledge of any attempted alternatives to the bed rails. LPN #3 stated Resident #105 was able to use the rails to turn in bed.

On /10/16/19 at 2:47 p.m., the director of nursing (DON) was interviewed about assessments for bed rail safety. The DON stated all the beds in the facility were purchased after 2006 and according to the bed manufacturer, had no entrapment zones. The DON stated a gap measurement device was ordered in case specialty mattresses were used. The DON stated maintenance performed safety checks on beds/mattresses and again stated the beds in the facility did not have entrapment risks. The DON presented a letter from the bed manufacturer stating the beds with rails and mattresses were

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purchased by the facility in 2009.

This finding was reviewed with the administrator and DON during meetings on 10/16/19 at 4:45 p.m. and 10/17/19 at 10:20 a.m.

4. Resident #37 was admitted to the facility on 5/19/16 with a re-admission on 10/3/19. Diagnoses for Resident #37 included chronic kidney disease, chronic obstructive pulmonary disease, atrial fibrillation, dementia, hypothyroidism, bladder cancer, high blood pressure, heart failure and arthritis. The minimum data set (MDS) dated 8/1/19 assessed Resident #37 with moderately impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility.

On 10/15/19 at 11:30 a.m., Resident #37's bed environment was inspected. The resident's bed had two quarter length side rails in the raised position near the head of the bed.

Resident #37's clinical record documented no assessment for entrapment risks related to use of the bed rails and no prior attempted alternatives to bed rail use.

Resident #37's clinical record documented a physician's order dated 10/3/19 for, "2 half side rails @ (at) head of bed to enable self turning and repositioning."

The most recent side rail assessment was dated 5/9/16 and listed the resident had altered safety awareness due to cognitive decline, a history of falls, poor bed mobility, history of postural hypotension, poor balance/trunk control and took medications that would require increased safety

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precautions. This form made no mention of any risks associated with the resident's use of bed rails and did not indicate any evaluation and/or recommendation regarding the resident's use of bed rails (recommendation section was blank). There were no prior attempted alternatives to side rails listed on the assessment or in the clinical record. The resident's family member signed a consent form on 5/19/16 documenting the potential risks for rails had been explained but no risks were identified on the form. The record documented no bed rail assessment regarding entrapment risks since 5/9/16.

The clinical record documented attempts by the resident to get out of bed unassisted. A nursing note dated 8/16/19 documented the resident was found with his legs over the bedside table, attempting to get out of bed. An additional note on 10/4/19 documented the resident was disoriented and attempting to climb out of his chair unassisted and was not responsive to re-direction.

Resident #37's plan of care (revised 10/3/19) listed the resident was at risk of falls due to impaired decision-making skills and a history of falls. Interventions for fall/injury prevention included, "...siderail use as needed/appropriate. Resident and POA request use of 2 1/2 upper siderails for safety and to promote turning and positioning while in bed and to be able to position self by using the controls..."

On 10/16/19 at 1:49 p.m., the certified nurses' aide (CNA #1) routinely caring for Resident #37 was interviewed. CNA #1 stated the resident used the bed rails when turning or repositioning in bed but required assistance from staff with bed

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F 700	Continued From page 19 mobility. On 10/16/19 at 1:52 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about bed rail assessments and bed safety. LPN #3 stated bed rail assessments were completed upon admission to see if the resident and/or responsible party wanted the rails. LPN #3 stated rails were re-assessed if the interdisciplinary team felt there was a need or if therapy made a recommendation about the rails. When asked about any assessment regarding Resident #37's bed rails use since 5/9/16, LPN #3 stated she did not see a recent assessment. LPN #3 stated she had no knowledge of any attempted alternatives to the bed rails. LPN #3 stated Resident #37 was able to hold the rails when staff assisted him with bed mobility. On /10/16/19 at 2:47 p.m., the director of nursing (DON) was interviewed about assessments for bed rail safety. The DON stated all the beds in the facility were purchased after 2006 and according to the bed manufacturer, had no entrapment zones. The DON stated a gap measurement device was ordered in case specialty mattresses were used. The DON stated maintenance performed safety checks on beds/mattresses and again stated the beds in the facility did not have entrapment risks. The DON presented a letter from the bed manufacturer stating the beds with rails and mattresses were purchased by the facility in 2009. This finding was reviewed with the administrator and DON during meetings on 10/16/19 at 4:45 p.m. and 10/17/19 at 10:20 a.m.	F 700		
F 756	Drug Regimen Review, Report Irregular, Act On	F 756		11/13/19

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F 756 SS=E	Continued From page 20 CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that

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F 756	Continued From page 21 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility's consultant pharmacist failed, for six of 28 residents in the survey sample, to identify and report medication irregularities to the Nurse Practitioner/attending physician/Medical Director. The consultant pharmacist failed to identify Residents # 69, 86, 60, 25, 32, and 3 as having physician orders for as needed (PRN) psychotropic medications that extended for more than 14 days without a stop date. The findings were: 1. Resident # 69 was admitted to the facility on 9/8/18 with diagnoses that included anemia, coronary artery disease, hypertension, arthritis, osteoporosis, Non-Alzheimer's dementia, anxiety disorder, and depression. According to the most recent Minimum Data Set (MDS), a Significant Change with an Assessment Reference Date (ARD) of 8/22/19, the resident was assessed under Section C (Cognitive Patterns) as having a Summary Score of 07 out of 15. Resident # 69's Electronic Health Record (EHR) included the following physician's orders for PRN psychotropic medications: Xanax (Alprazolam) 0.5 mg (milligrams) - 0.5 mg by mouth every 6 hours as needed for anxiety disorder. The order date and start date were 9/24/19. There was no stop date listed on the order. According to the E-MAR (Electronic Medication Administration Record), Xanax was administered once on each of four days; 10/4/19, 10/7/19, 10/9/19, and 10/12/19.	F 756	F-756 Drug Regimen Review; 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Medication orders for residents identified #69, #86, #60, #25, #32, and #3 had orders revised during the survey to reflect an official stop date for the PRN medications that extended beyond 14 days. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; In collaboration with our Medical Director and FNP we are developing a specific PRN template to include the following medications: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic. The language for the newly developed template will include: a specific length of time for the PRN medication and indicate the reasoning for extending the PRN medication beyond 14 days. This will ensure consistency among all physician orders for PRN medications. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not recur;	

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F 756	Continued From page 22 According to Resident # 69's EHR, a Medication Regimen Review was conducted by the consultant pharmacist on 10/9/19 and forwarded to the Nurse Practitioner. The pharmacist's review noted the following, "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities." The pharmacist's review failed to identify the resident's 9/24/19 PRN Xanax order as not having a stop date. At 9:25 a.m. on 10/17/19, the consultant pharmacist was interviewed by telephone. When told about the concern with PRN psychotropic medications being ordered without a stop date, the pharmacist was asked how he addresses them. "We monitor the GDR (Gradual Dose Reduction)," the pharmacist said. He went on to say that, "We do not manage the stop dates on PRN medications. We don't supply more than 14 days worth of medications. We supply enough to stop at 13 days." The pharmacist indicated that all (PRN's) should get a stop date, but that "We rely on the physician to justify the use beyond 14 days." During a meeting at 10:00 a.m. on 10/17/19, that included the Director of Nursing, Administrator, and the survey team, the discussion with the pharmacist was reviewed. 2. Resident # 86 was admitted to the facility on 6/10/19 with diagnoses that included anemia, heart failure, hypertension, depression, gastroesophageal reflux disease, pleural effusion,	F 756	Wellness concepts Pharmacy attends our QAPI meetings on a monthly basis. Our QAPI team will run a PRN report to review during our QAPI meeting. Any discrepancies in this new process and practice will be addressed at that time. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; BRC will utilize our QAPI reporting tools and systems to monitor performance for the new PRN template. Information will be tracked on a monthly basis to evaluate trends in practice and standards. 5. Include date(s) when the corrective action will be completed for each identified deficient practice. The PRN template is in process for our QAPI review. Completion date for the PRN template will be November 13, 2019.	

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F 756	Continued From page 23	F 756		

and hypothyroidism. According to the most recent MDS, a Quarterly review with an ARD of 9/9/10, the resident was assessed under Section C (Cognitive Patterns) as having a Summary Score of 06 out of 15.

Resident # 86's EHR included the following physician's order for a PRN psychotropic medication: Lorazepam Intensol 2 mg/ml (milligrams per milliliter) oral concentrate. Give 0.5 ml by mouth every 3 hours as needed for anxiety, for end of life care, agitation. The order date and start date were 10/1/19. There was no stop date listed on the order.

According to Resident # 86's EHR, a Medication Regimen Review was conducted by the consultant pharmacist on 10/9/19 and forwarded to the Nurse Practitioner. The pharmacist's review noted the following, "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities." The pharmacist's review failed to identify the resident's 10/1/19 PRN Lorazepam order as not having a stop date.

3. Resident # 60 was admitted to the facility on 5/25/19 with diagnoses that included heart failure, hypertension, orthostatic hypotension,gastroesophageal reflux disease, ulcerative colitis, diabetes mellitus, hyperlipidemia, Parkinson's Disease, depression, chronic obstructive pulmonary disease, chronic pain syndrome, restless leg syndrome, sleep apnea, and dysphagia. According to the most recent MDS, a Significant Change with an ARD of

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8/16/19, the resident was assessed under Section C (Cognitive Patterns) as having a Summary Score of 10 out of 15.

Resident # 60's EHR included the following physician's order for a PRN psychotropic medication: Lorazepam 2 mg/ml oral concentrate - 0.5 ml = 1 mg by mouth every 3 hours as needed for anxiety/agitation/end of life care. The order date and start date were 7/19/19. There was no stop date listed on the order.

There was also a second order for oral Lorazepam: Lorazepam 2 mg/ml oral concentrate. 1 ml by mouth every 3 hours as needed for moderate to severe anxiety, agitation, end of life care. The order date and start date were 8/13/19. There was no stop date listed on the order.

According to the E-MAR in the resident's EHR, the Lorazepam ordered on 8/13/19 was administered once on each of two days; 10/12/19 and 10/13/19.

According to Resident # 60's EHR, a Medication Regimen Review was conducted by the consultant pharmacist on 8/14/19, 9/4/19, and 10/9/19, and forwarded to the Nurse Practitioner. The pharmacist's review noted the following, "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities." The pharmacist's review failed to identify the resident's 7/19/19 PRN Lorazepam order as not having a stop date.

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Additionally, the Medication Regimen Reviews conducted by the consultant pharmacist on 8/14/19, 9/4/19, and 10/9/19, and forwarded to the Nurse Practitioner, failed to identify the resident's 8/13/19 PRN Lorazepam order as not having a stop date.

4. Resident #25 was admitted to the facility on 03/16/18 with diagnoses that included, hypertension, hyperlipidemia, Alzheimer's Dementia with out behavioral disturbances, abnormal gait and mobility, history of traumatic fracture and gastro-esophageal reflux disease (GERD). The most recent minimum data set (MDS) dated 07/23/19 which was a significant change assessment, assessed Resident #25 as severely impaired with a score of 3 out of 15 for daily decision making.

On 10/15/19 at 12:50 p.m., Resident #25's clinical record was reviewed. Observed on the physician orders was the following order: "Order #530. Order Date/Start Date: 04/17/19. Lorazepam 2mg/ml (milligrams/milliliters) oral concentrate (generic) - Give 0.5ml=1mg By Mouth Every 3 hours as needed For anxiety/agitation r/t (related to) encounter for comfort measures: [Name of Physician]."

There was no documented stop date for the PRN Lorazepam order.

A review of Resident #25's clinical record revealed the consultant pharmacist conducted monthly drug regimen reviews. For the months of May, June, July, August, September, and October 2019 the pharmacy reviews documented the following: "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information,

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it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities." There was no documentation to indicate the pharmacist identified the PRN order for Lorazepam as being outside of the 14 day prescription range.

On 10/17/19 at 9:20 a.m., the pharmacist was interviewed regarding identifying PRN psychotropic medications with no stop date during the monthly drug regimen reviews. The pharmacist stated "we do not manage stop dates for PRN medications, we depend on the doctor to do that."

These findings were shared with the administrator and director of nurse during a meeting on 10/17/19 at 10:15 a.m.

No additional information was provided to the survey team prior to exit on 10/17/19 at 11:00 a.m.

5. Resident #32 was admitted to the facility on 04/22/19 with diagnoses that included: Parkinson's Disease, hypertension, restless leg syndrome, delusional disorder, and Lewy body dementia. The most recent minimum data set (MDS) dated 07/29/19 which was a quarterly assessment, assessed Resident #32 has severely impaired for daily decision making and having long and short term memory problems.

On 10/16/19 at 4:15 p.m., Resident #32's clinical record was reviewed. Observed on the physician orders was the following order: "Order #560. Order Date/Start Date: 08/02/2019. Buspirone 15 mg tablet (generic) - 1/2 tab=7.5mg By Mouth Daily as needed For anxiety/agitation;

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DELUSIONAL DISORDERS; DEMENTIA WITH LEWY BODY, anxiety/agitation; DELUSIONAL DISORDERS; DEMENTIA WITH LEWY BODY; [Name of Physician]."

There was no stop date for the PRN Buspirone order.

A review of Resident #32's clinical record revealed the consultant pharmacist conducted monthly drug regimen reviews. For the months of August, September, and October 2019 the pharmacy reviews documented the following: "Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities." There was no documentation to indicate the pharmacist identified the PRN order for Buspirone as being outside of the 14 day prescription range.

On 10/17/19 at 9:20 a.m., the pharmacist was interviewed regarding identifying PRN psychotropic medications with no stop date during the monthly drug regimen reviews. The pharmacist stated "we do not manage stop dates for PRN medications, we depend on the doctor to do that."

These findings were shared with the administrator and director of nurse during a meeting on 10/17/19 at 10:15 a.m.

No additional information was provided to the survey team prior to exit on 10/17/19 at 11:00 a.m.

6. Resident #3 was originally admitted to the

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facility on 11/25/2014 and readmitted on 06/10/2019 with diagnoses including, but not limited to: Dementia, Anxiety, Depression, Congestive Heart Failure, and Pulmonary Fibrosis.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/01/2019. Resident #3 was assessed as severely impaired in her cognitive status with a total cognitive score of six out 15.

Resident #3's clinical record was reviewed on 10/16/2019 at 8:07 a.m. The physician order sheet (POS) dated October 2019 included, "...Order Date: 06/20/19, Start Date: 06/20/19 Lorazepam Intensol 2 mg/ml [milligrams/milliliter] oral concentrate...- Give 0.5mls By Mouth Every 3 hours As Needed 5ml=0.5 mg...for Anxiety For agitation ; Behavior..."

Subsequent review of Resident #3's MAR's (medication administration sheets) dated June through October 2019 included documentation that Resident #3 received only one prn (as needed) dose of Ativan on 08/21/2019.

Pharmacy reviews dated July, August, September, and October 2019 all included, "...No new irregularities..." The facility pharmacist was interviewed via phone on 10/17/2019 at 9:25 a.m. regarding why no recommendations had been made to the physician for a prn medication ordered for more than 14 days. The pharmacist stated, "We monitor GDR [gradual dose reduction]. We do not manage stop dates on prn meds. We rely on the physician to justify use beyond 14 days."

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F 756	Continued From page 29 The Administrator and DON (director of nursing) were informed of the above mentioned information during a meeting with the survey team on 10/17/2019 at 10:15 a.m. No further information was received prior to the exit conference.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		11/13/19

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F 758	Continued From page 30 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure six of 28 residents were free of unnecessary psychotropic medications. Residents # 69, 86, 60, 25, 32, and 3 had physician orders for as needed (PRN) psychotropic medications that extended for more than 14 days without a stop date. The findings include: 1. Resident # 69 was admitted to the facility on 9/8/18 with diagnoses that included anemia, coronary artery disease, hypertension, arthritis, osteoporosis, Non-Alzheimer's dementia, anxiety disorder, and depression. According to the most recent Minimum Data Set (MDS), a Significant Change with an Assessment Reference Date (ARD) of 8/22/19, the resident was assessed under Section C (Cognitive Patterns) as having a Summary Score of 07 out of 15.	F 758	F-758 Free from Unnec Psychotropic Meds/PRN 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Medication orders for residents identified #69, #86, #60, #25, #32, and #3 had orders revised during the survey to reflect an official stop date for the PRN medications that extended beyond 14 days. Our new PRN template will require our MD, FNP to thoroughly assess the appropriate use for anti-psychotic, anti-depressant, anti-anxiety, and hypnotic. For medications not being administered, considerations will be made to discontinue those medications.	

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F 758	Continued From page 31 Resident # 69's Electronic Health Record (EHR) included the following physician's orders for PRN psychotropic medications: Xanax (Alprazolam) 0.5 mg (milligrams) - 0.5 mg by mouth every 6 hours as needed for anxiety disorder. The order date and start date were 9/24/19. There was no stop date listed on the order. According to the E-MAR (Electronic Medication Administration Record), Xanax was administered once on each of four days; 10/4/19, 10/7/19, 10/9/19, and 10/12/19. NOTE: Xanax (Alprazolam) is an antianxiety medication used to treat anxiety, panic disorders with or without agoraphobia, and anxiety with depressive symptoms. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 41. Seroquel (Quetiapine) 50 mg PLO cream. Give 50 mg when resident doesn't take po (oral) dose. 50 mg topical 3 times a day as needed when she will not take po dose for delusional disorders. Apply cream to wrist area per NP (Nurse Practioner). The order date and start date were 10/16/19. There was no stop date listed on the order. NOTE: Seroquel (Quetiapine) is an antipsychotic used in the treatment of depression, with unlabeled uses for agitation and dementia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 998. At 4:00 p.m. on 10/16/19, a meeting was held that included the Director of Nursing (DON), the Nurse Practitioner (NP), and the survey team. During the meeting, the use of PRN psychotropic	F 758	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; In collaboration with our Medical Director and FNP we are developing a specific PRN template to include the following medications: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic. The language for the newly developed template will include: a specific length of time for the PRN medication and indicate the reasoning for extending the PRN medication beyond 14 days. This will ensure consistency among all physician orders for PRN medications and will address the unnecessary use of medications within this classification. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not recur; Wellness concepts Pharmacy attends our QAPI meetings on a monthly basis. Our QAPI team will run a PRN report to review during our QAPI meeting. Any discrepancies in this new process and practice will be addressed at that time. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; BRC will utilize our QAPI reporting tools and systems to monitor performance for the new PRN template. Information will be	

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F 758	Continued From page 32 medications was discussed. The NP stated she had been in contact with the consultant pharmacist and been told the 14 day PRN restriction did not apply to antipsychotic medications. The survey team referred the DON and the NP to the section of the State Operations Manual dealing with PRN psychotropic medications, and noted the full spectrum of psychotropic medications is covered by the regulation. 2. Resident # 86 was admitted to the facility on 6/10/19 with diagnoses that included anemia, heart failure, hypertension, depression, gastroesophageal reflux disease, pleural effusion, and hypothyroidism. According to the most recent MDS, a Quarterly review with an ARD of 9/9/10, the resident was assessed under Section C (Cognitive Patterns) as having a Summary Score of 06 out of 15. Resident # 86's EHR included the following physician's order for a PRN psychotropic medication: Lorazepam Intensol 2 mg/ml (milligrams per milliliter) oral concentrate. Give 0.5 ml by mouth every 3 hours as needed for anxiety, for end of life care, agitation. The order date and start date were 10/1/19. There was no stop date listed on the order. NOTE: Lorazepam (Ativan) is an antianxiety medication used in the treatment of anxiety with an unlabeled use for agitation. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722. 3. Resident # 60 in the survey sample, an 80 year-old male, was admitted to the facility on 5/25/19 with diagnoses that included heart failure,	F 758	tracked on a monthly basis to evaluate trends in practice and standards. 5. Include date(s) when the corrective action will be completed for each identified deficient practice. The PRN template is in process for our QAPI review. Completion date for the PRN template will be November 13, 2019.	

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hypertension, orthostatic hypotension,gastroesophageal reflux disease, ulcerative colitis, diabetes mellitus, hyperlipidemia, Parkinson's Disease, depression, chronic obstructive pulmonary disease, chronic pain syndrome, restless leg syndrome, sleep apnea, and dysphagia. According to the most recent MDS, a Significant Change with an ARD of 8/16/19, the resident was assessed under Section C (Cognitive Patterns) as having a Summary Score of 10 out of 15.

Resident # 60's EHR included the following physician's order for a PRN psychotropic medication: Lorazepam 2 mg/ml oral concentrate - 0.5 ml = 1 mg by mouth every 3 hours as needed for anxiety/agitation/end of life care. The order date and start date were 7/19/19. There was no stop date listed on the order.

There was also a second order for oral Lorazepam: Lorazepam 2 mg/ml oral concentrate. 1 ml by mouth every 3 hours as needed for moderate to severe anxiety, agitation, end of life care. The order date and start date were 8/13/19. There was no stop date listed on the order.

According to the E-MAR in the resident's EHR, the Lorazepam ordered on 8/13/19 was administered once on each of two days; 10/12/19 and 10/13/19.

4. Resident #25 was admitted to the facility on 03/16/18 with diagnoses that included, hypertension, hyperlipidemia, Alzheimer's Dementia with out behavioral disturbances, abnormal gait and mobility, history of traumatic fracture and gastro-esophageal reflux disease (GERD). The most recent minimum data set

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(MDS) dated 07/23/19 which was a significant change assessment, assessed Resident #25 as severely impaired with a score of 3 out of 15 for daily decision making.

On 10/15/19 at 12:50 p.m., Resident #25's clinical record was reviewed. Observed on the physician orders was the following order: "Order #530. Order Date/Start Date: 04/17/19. Lorazepam 2mg/ml (milligrams/milliliters) oral concentrate (generic) - Give 0.5ml=1mg By Mouth Every 3 hours as needed For anxiety/agitation r/t (related to) encounter for comfort measures: [Name of Physician]."

There was no documented stop date for the PRN Lorazepam order.

A review of the medication administration record (MAR) for the period of 04/17/19 through 10/15/19 documented that Resident #25 did not receive any doses of the PRN Lorazepam.

On 10/16/19 at 2:10 p.m. the clinical coordinator (LPN #2) on Resident #25's unit was interviewed regarding the PRN Lorazepam order. LPN #2 stated Resident #25's daughter was concerned about discontinuing the PRN Lorazepam order because Resident #25 had a history of seizures and thought the resident may need the medication since she had a recent fracture. LPN #2 continued and stated the facility's nurse practitioner felt it was better to leave the order in place since Resident #25 was on comfort care.

On 10/16/19 at 4:00 p.m. LPN #2, the facility's nurse practitioner and the director of nursing (DON) came to the conference room to discuss the 14 day psychotropic medication regulation.

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The nurse practitioner and DON stated they thought the 14 day PRN regulation only applied to antipsychotic medications and additionally if a resident was on hospice or comfort care then this was rational to have the PRN order and the consultant pharmacist was in agreement with this.

No additional information was provided to the survey team prior to exit on 10/17/19 at 11:00 a.m.

5. Resident #32 was admitted to the facility on 04/22/19 with diagnoses that included: Parkinson's Disease, hypertension, restless leg syndrome, delusional disorder, and Lewy body dementia. The most recent minimum data set (MDS) dated 07/29/19 which was a quarterly assessment, assessed Resident #32 has severely impaired for daily decision making and having long and short term memory problems.

On 10/16/19 at 4:15 p.m., Resident #32's clinical record was reviewed. Observed on the physician orders was the following order: "Order #560. Order Date/Start Date: 08/02/2019. Buspirone 15 mg tablet (generic) - 1/2 tab=7.5mg By Mouth Daily as needed For anxiety/agitation; DELUSIONAL DISORDERS; DEMENTIA WITH LEWY BODY, anxiety/agitation; DELUSIONAL DISORDERS; DEMENTIA WITH LEWY BODY; [Name of Physician]."

There was no stop date for the PRN Buspirone order.

A review of the medication administration record (MAR) for the period of 08/02/19 through 10/16/19 documented that Resident #32 received a dose of the PRN Buspirone on 08/20/19 and

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09/08/19.

These findings were shared with the administrator and director of nursing during a meeting on 10/16/19 at 4:30 p.m.

On 10/17/19 at 9:30 a.m., the clinical coordinator (LPN #2) on Resident #32's unit was interviewed regarding the PRN Buspirone order. LPN #2 stated Resident #32 is followed by psychiatry and in August 2019 his wife had some concerns with the administration times of the PRN Buspirone and requested the administration time change. LPN #2 stated Resident #32 has not displayed a lot of delusions or hallucinations has he did in the past. LPN #2 continued and stated the staff has developed person centered activities and care plans based on his likes and needs which have seemed to help with some of the behaviors especially in the afternoon.

No additional information was provided to the survey team prior to exit on 10/17/19 at 11:00 a.m.

6. Resident #3 was originally admitted to the facility on 11/25/2014 and readmitted on 06/10/2019 with diagnoses including, but not limited to: Dementia, Anxiety, Depression, Congestive Heart Failure, and Pulmonary Fibrosis.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/01/2019. Resident #3 was assessed as severely impaired in her cognitive status with a total cognitive score of six out 15.

Resident #3's clinical record was reviewed on 10/16/2019 at 8:07 a.m. The physician order

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sheet (POS) dated October 2019 included, "...Order Date: 06/20/19, Start Date: 06/20/19 Lorazepam Intensol 2 mg/ml [milligrams/milliliter] oral concentrate...- Give 0.5mls By Mouth Every 3 hours As Needed 5ml=0.5 mg...for Anxiety For agitation; Behavior..."

Subsequent review of Resident #3's MAR's (medication administration sheets) dated June through October 2019 included documentation that Resident #3 received only one prn (as needed) dose of Ativan on 08/21/2019.

Review of Physician Progress Notes dated 6/20/19, 8/15/19, 9/12/19, and 10/15/19 included: "...Review of Systems...Psychiatric: No acute AMS [altered mental status] today...Psychiatric: Awake and oriented to person. Pleasant affect today, talkative. Appropriate and cooperative for exam. Does not appear in distress today...Plan: ...Ativan Intensol 2 mg/ml, 1 mg PO/SL [oral/sublingual] q [every] 3 hrs PRN [as needed] anxiety, agitation, end-of -life care...comfort measures medication..."

The Nurse Practitioner (Administration #3) was interviewed on 10/16/2019 at approximately 4:00 p.m. regarding Resident #3's prn Ativan order. The NP stated, "She is on comfort measures. She has really bad respiratory issues. The pharmacist told us the 14 day order only pertained to antipsychotic medications."

The Administrator and DON (director of nursing) were informed of the above mentioned information during a meeting with the survey team on 10/17/2019 at 10:15 a.m. No further information was received prior to the exit conference.

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F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		11/4/19

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F 791	Continued From page 39 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide routine dental services for one of 28 residents in the survey sample. Resident #47, with obvious decayed/deteriorated teeth, had not been offered or provided dental services since her admission on 8/30/18. The findings include: Resident #47 was admitted to the facility on 8/30/18 with a re-admission on 9/12/18. Diagnoses for Resident #47 included wrist fracture, gastroesophageal reflux disease, depression, anemia, high blood pressure and history of pulmonary embolism. The MDS dated 8/8/19 assessed Resident #47 as cognitively intact. On 10/15/19 at 12:00 p.m., Resident #47 was interviewed about quality of life in the facility. Resident #47's bottom, front teeth were broken with black/gray discoloration. Several of the lower front teeth had visible decay and were broken near the gum. The resident's top front teeth were chipped. Resident #47 was interviewed at this time about her teeth. The resident stated she had a partial plate on the top and her front teeth on the plate were chipped. Resident #47 stated her bottom teeth were not in good condition and needed repair. Resident #47 stated she had not been offered dental services since she had been in the facility and would like	F 791	F-791 Routine/Emergency Dental Services 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #47 has a scheduled appointment with Community Dental Health on November 19, 2019 for a complete dental assessment. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Clinical Coordinator (CC) team, QAPI Coordinator, Infection Preventionist, and DON met with the RD following the survey finding on 10/23/19 for reviewing Section L; L0200 Dental. It was discussed as a team and we concluded that Section L; L0200 will be completed by the Clinical Coordinator within each respective household. Any noted dental needs will be addressed at that time with resident and MPOA. 3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not recur;	

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F 791	Continued From page 40 to see a dentist about her teeth. The clinical record documented no assessment of Resident #47's decayed teeth and chipped partial plate. Section L0200 of the annual MDS dated 8/8/19 inaccurately documented the resident had no dental problems. The admission MDS dated 9/6/18 included no assessment of the resident's teeth and indicated staff were "unable to examine" the resident's dental status with no explanation why the examination was not completed. The resident's plan of care (revised 8/29/19) made no mention of the resident's poor dentition. On 10/16/19 at 2:08 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about Resident #47's teeth. LPN #3 stated the registered dietitian (RD) was responsible for completing section L0200 regarding the assessment of resident's dental status. LPN #3 stated the dental section on the 8/8/19 MDS was not accurate as the resident had obvious decayed lower, front teeth. LPN #3 stated the resident had not complained about dental pain and the resident's family made her outside appointments. When asked about dental services provided by the facility, LPN #3 stated residents were sent out for dental services but they currently did not have a dental provider for Medicaid participants. On 10/16/19 at 2:30 p.m., the social worker (other staff #1) was interviewed about dental services for Resident #47. The social worker stated Resident #47 had not been offered or provided dental services since she had been in the facility. The social worker stated there were limited dental providers in the area that would assess and provide services for geriatric, Medicaid residents.	F 791	From a logistical perspective, the Clinical Coordinator (CC) will have direct oversight for the accurate completion of Section L; L0200. The RD will no longer have responsibility to conducting the oral health screening for each resident as this will be completed by the CC. The dental screening/ assessment will be completed upon admission and reviewed as needed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The practice for completing Section L; L0200 will be permanently assigned to the Clinical Coordinator (CC). 5. Include date(s) when the corrective action will be completed for each identified deficient practice. This practice will be fully implemented by 10/28/19. Overview of Section L; 0200 regarding additional residents that may be affected by this practice will be completed by 11/4/19.	

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F 791	Continued From page 41 This finding was reviewed with the administrator and director of nursing during a meeting on 10/17/19 at 4:45 p.m.	F 791		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, staff interview and clinical record review, the facility staff failed to perform bed safety inspections with use of specialty mattresses for two of 28 residents in the survey sample. Resident #10 had a wide bed with a concave mattress and bed rails in use without a prior inspection for possible entrapment risks. Resident #23 had an air mattress with bed rails in use without a prior inspection for possible entrapment risks. The findings include: 1. Resident #10 was admitted to the facility on 11/21/13 with a re-admission on 8/9/16. Diagnoses for Resident #10 included schizoaffective disorder, bipolar disorder, depression, bladder spasms, anxiety, anemia, sleep apnea, chronic obstructive pulmonary disease, spinal stenosis, macular degeneration,	F 909	F-909 Resident Bed 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. A new and appropriately proportioned mattress to accommodate the wider bed frame was placed on resident#10's bed 10/23/19 by maintenance. Followed by a safety check for bed/mattress compliance. An updated Bed Safety Siderail Entrapment Assessment will be completed by 10/30/19. Resident # 23 had a successful safety electrical check for the air mattress pump on 10/25/19. An updated Bed Safety Siderail Entrapment Assessment will be completed by 10/30/19. BRC does not require a physician's order for an air mattress, the	11/6/19

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and diabetes. The minimum data set (MDS) dated 7/11/19 assessed Resident #10 with short and long-term memory problems and severely impaired cognitive skills. This MDS listed the resident required the extensive assistance of two people for bed mobility.

On 10/16/19 at 10:00 a.m., Resident #10's bed environment was inspected. The resident's bed had two quarter length side rails in the raised position near the head of the bed. There was a concave shaped mattress on the bed with an approximately 6-inch gap from the end of the mattress to the headboard. There was approximately a 2-inch gap from the bottom of the mattress to the bed's footboard.

Resident #10's clinical record documented no assessment of bed safety or entrapment risks related to the concave mattress used with the side rails. The record documented a physician's order dated 9/5/17 for "2 half side rails @ (at) head of bed to enable self turning and positioning."

The most recent side rail assessment was dated 11/21/13 and made no mention of any risks for Resident #10 with use of the rails. The record documented no bed assessment regarding the concave mattress and no other bed rail assessment since 11/21/13.

On 10/16/19 at 1:52 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about bed rail assessments and concave mattress. LPN #3 stated bed rail assessments were completed upon admission to see if the resident and/or responsible party wanted the rails. LPN #3 stated maintenance installed the

air mattress was listed in “point of care” as per our policy. Resident #105 will have an updated Bed Safety Siderail Entrapment Assessment completed by 10/30/19. Resident #37 will have an updated Bed Safety Siderail Entrapment Assessment completed by 10/30/19. Our current Bed Safety Siderail Entrapment Assessment and consent forms will be revised and updated by November 6, 2019 to include verbiage regarding risks associated with the use of siderails and alternatives to siderails when appropriate.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

BRC will implement the newly revised Bed Safety Siderail Entrapment Assessment 11/6/19. This assessment will be required to be completed: Quarterly, A noted significant change in the resident’s condition, Anytime the resident’s compliment is changed (air mattress, or additional siderail).

3. Address what measures will be put in place, or what systemic changes will be made to ensure the deficient practice will not recur;

The systemic change in practice will be reviewed weekly during our Clinical Coordinator and QAPI meetings each Wednesday. If a resident requires changes to their current bed, mattress, rails, etc. Nursing will notify maintenance for further assessment and appropriate

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F 909	Continued From page 43 mattress and was responsible for bed safety checks when mattresses were changed. On /10/16/19 at 2:47 p.m., the director of nursing (DON) was interviewed about assessments for bed rail safety. The DON stated all the beds in the facility were purchased after 2006 and according to the bed manufacturer, had no entrapment zones. The DON stated a gap measurement device was ordered in case specialty mattresses were used. The DON stated maintenance performed bed safety checks and again stated the beds in the facility did not have entrapment risks. The DON presented a letter from the bed manufacturer stating the beds with rails and mattresses were purchased by the facility in 2009. On 10/16/19 at 4:20 p.m., the maintenance supervisor (other staff #2) was interviewed about bed safety inspections. The maintenance supervisor stated he checked beds/mattresses/rails once per year. The maintenance director stated they checked to be sure the mattress and bed were in good condition and that the side rails functioned properly. The maintenance director stated he did not perform "gap measurements" because their bed manufacturer informed them they complied with FDA [Food and Drug Administration] bed safety guidelines when the beds were purchased. The maintenance supervisor stated if a specialty mattress was installed, a bed safety check was supposed to be performed. The maintenance supervisor stated the facility purchased a device to perform gap measurements with special beds and/or mattresses but no gap measurements had been performed.	F 909	placement of the needed items. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Quarterly reports will be generated via our EMR for QAPI oversight. Our Maintenance Director will receive the generated list to ensure bed inspections are current and accurate for all residents. 5. Include date(s) when the corrective action will be completed for each identified deficient practice. Resident #10's mattress corrected 10/23/19. Resident #23 successful inspection of air mattress pump 10/25/19. Resident #10, #23, # 105, & # 37 will have updated Bed Safety Siderail Entrapment Assessments completed by 11/6/19. Bed Safety Siderail Entrapment Assessment and consent forms will be revised and updated by November 6, 2019 to include verbiage regarding risks associated with the use of siderails and alternatives to siderails when appropriate.	

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On 10/16/19 at 4:32 p.m., accompanied by the maintenance supervisor, Resident #10's bed, rails and mattress were inspected. The maintenance supervisor was shown and interviewed about the approximately 6-inch gap between the mattress and the head of the bed. The maintenance supervisor identified Resident #10's bed as bed #60. The maintenance supervisor stated concerning the gap, "Yes. That's a concern." The maintenance supervisor stated a safety check had not been performed on this bed with the concave mattress in place. The maintenance supervisor stated he was not aware the concave mattress had been installed and that Resident #10's bed was a "wide" bed and not the standard resident bed.

The maintenance supervisor presented documented bed inspection records. Bed number 60 was most recently inspected in November 2018 and had not been inspected with use of a concave mattress. The maintenance supervisor was not sure when the "wide" bed was placed with the resident. The bed inspection sheets made no reference to any special beds or specialty mattresses in use in the facility.

On 10/16/19 at 4:54 p.m., the DON was interviewed again about any resident assessment regarding bed rails and the specialty, concave mattress. The DON stated Resident #10 started using the concave mattress in May 2019.

These findings were reviewed with the administrator and DON during meetings on 10/16/19 at 4:45 p.m. and 10/17/19 at 10:20 a.m.

2. Resident #23 was admitted to the facility on 12/23/13 with diagnoses that included congestive

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heart failure, high blood pressure, spinal stenosis, chronic kidney disease, chronic pain, anxiety, tremors, diabetes with neuropathy and anemia. The minimum data set (MDS) dated 7/18/19 assessed Resident #23 with moderately impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility.

On 10/15/19 at 3:30 p.m., Resident #23 was in bed. Two quarter length bed rails were in the raised position near the head of the bed. An alternating air mattress was in place on the bed. Resident #23 was observed again on 10/16/19 at 10:00 a.m. and 11:00 a.m. in bed with the air mattress in place with raised bed rails.

Resident #23's clinical record documented no assessment of entrapment risks related to the bed rails or the alternating air mattress.

Resident #23's clinical record documented a physician's order dated 9/5/17 for "2 side rails @ head of bed to enable self turning and repositioning." The was no physician's order for the air mattress but it was listed as an intervention under "point of care" devices for skin protection.

The most recent side rail assessment was dated 12/23/13. This form made no mention of any risks associated with the resident's use of bed rails and stated the resident required the rails to promote independence and to provide safety. A consent form was signed by the resident on 12/23/13 documented the potential risks for rails had been explained but no risks of the rails were identified or listed on the form. The record documented no bed assessment regarding the air mattress and no other bed rail assessment since

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12/23/13.

On 10/16/19 at 1:52 p.m., the licensed practical nurse (LPN #3) unit manager was interviewed about bed rail assessments and the air mattress. LPN #3 stated bed rail assessments were completed upon admission to see if the resident and/or responsible party wanted the rails. LPN #3 stated maintenance installed the air mattress and was responsible for bed safety checks when mattresses were changed.

On /10/16/19 at 2:47 p.m., the director of nursing (DON) was interviewed about assessments for bed rail safety. The DON stated all the beds in the facility were purchased after 2006 and according to the bed manufacturer, had no entrapment zones. The DON stated a gap measurement device was ordered in case specialty mattresses were used. The DON stated maintenance performed safety checks on beds/mattresses and again stated the beds in the facility did not have entrapment risks. The DON presented a letter from the bed manufacturer stating the beds with rails and mattresses were purchased by the facility in 2009.

On 10/16/19 at 4:20 p.m., the maintenance supervisor (other staff #2) was interviewed about bed safety inspections. The maintenance supervisor stated he checked beds/mattresses/rails once per year. The maintenance director stated they checked to be sure the mattress and bed were in good condition and that the side rails functioned properly. The maintenance director stated he did not perform "gap measurements" because their bed manufacturer informed them they complied with FDA [Food and Drug Administration] bed safety

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER HOME , INC.	302 NORTH SECOND STREET BRIDGEWATER, VA 22812

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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guidelines when the beds were purchased. The maintenance supervisor stated if a specialty mattress was installed, a bed safety check was supposed to be performed. The maintenance supervisor stated the facility purchased a device to perform gap measurements with special beds and/or mattresses but no gap measurements had been performed.

On 10/16/19 at 4:32 p.m., accompanied by the maintenance supervisor, Resident #23's bed, rails and air mattress were inspected. The maintenance supervisor was interviewed about the air mattress in use. The maintenance supervisor stated he had not performed a bed inspection with the air mattress in place. The maintenance director stated he was not aware the air mattress was installed on the bed. The maintenance director identified Resident #23's bed as bed #102.

The maintenance supervisor presented documented bed inspection records. Bed number 102 was most recently inspected in November 2018. There was no documentation of any inspection of bed number 102 with a specialty air mattress. The bed inspection sheets made no reference to any special beds and or specialty mattresses in use in the facility.

On 10/16/19 at 4:54 p.m., the DON stated Resident #23's air mattress had been in use since February 2019.

These findings were reviewed with the administrator and DON during meetings on 10/16/19 at 4:45 p.m. and 10/17/19 at 10:20 a.m.