STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315340	A. BUILDING _____ B. WING _____	C 07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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
F 000	INITIAL COMMENTS Complaint #: NJ147243 Census: 86 Sample Size: 3 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ147243 Based on interviews, record review, and facility policy review, it was determined that the facility failed to investigate to determine the causative factors of falls to help prevent and/or reduce risk for falls and implement new fall interventions, if needed; and failed to ensure fall interventions were implemented to help prevent falls. This affected 1 of 3 residents (Resident #1) reviewed for falls. Resident #1 had [redacted], with one fall that resulted in a [redacted]. Findings included: 1. Resident #1 was admitted to the facility on [redacted] with diagnoses that included [redacted] closed [redacted] of	F 689	1.Safety Committee reviewed care plan for resident #1. Resident # 1 is expired. All future care plans interventions will be added with the date initiated following safety committee review with a root cause analysis completed. Nurses to sign off every shift that alarms are functioning and place. 2.All current residents at risk for falls may be affected if a new/different intervention is not on the care plan after safety committee review and root cause analysis completed. Residents also may be affected if alarm check for function and placement is not completed. 3.All falls will be reviewed weekly during	9/21/21

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

Electronically Signed | 08/13/2021

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F 689	Continued From page 1 [redacted] of the [redacted] A review of Resident #1's medical records revealed the resident was placed on hospice on [redacted] due to [redacted] and [redacted]. A review of Resident #1's [redacted] nurse's notes from [redacted] through [redacted] revealed that Resident #1 was an extreme [redacted] risk due to [redacted] episodes and was no longer able to ambulate with or without assistance. Resident #1 expired on [redacted] in the facility. Resident #1 had a care plan that indicated the resident was at risk for [redacted] related to impaired mobility, [redacted], and use of [redacted] medications. The resident had the following care plan interventions as of [redacted] -receive assistance with transfers to reduce the risk of falls -receive assistance with locomotion as needed -receive assistance with walking -provide clutter free environment -place call bell within reach, with prompt response to all requests -attend activities that do not put resident at risk for falls -ensure resident wears appropriate, well-fitting footwear to minimize the risk of slipping -mobility devices/equipment side rails, wheelchair -full side rails x 2 -rehab evaluation and follow up as ordered Additional interventions added to the care plan included the following:	F 689	resident safety committee meeting to ensure interventions are added/updated along with the date initiated after root cause analysis completed. Nurse unit managers and Nursing Supervisors will educate the nursing staff on the units of the new interventions to help prevent falls and injuries. DON or designee will reeducate nurses on policy to check alarms every shift and document on resident's treatment record. Physician orders obtained for the alarms and to be checked for placement and function for safety every shift. Unit Managers and/or Supervisors will conduct weekly alarm audit checks to ensure function and placement of alarms. All residents were audited and assessed for bed rails and 11 bedrails were removed. Fall prevention in-services completed. DON and/or designee will conduct observation audits monthly to ensure plan of care is being followed and will conduct weekly observation audits on alarms. 4.DON or her designee will conduct audits on resident care plans once a month for six months on the residents identified with a history of falls (for all falls occurring in the past year)to ensure that different interventions on the care plans are being implemented after a root cause analysis is conducted by the resident safety committee/IDC team. The DON or designee will also conduct treatment record audits and observation audits for alarms weekly to ensure that nursing staff are completing and signing off on alarm function and placement every shift. DON or designee will report all care plan and	

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F 689	Continued From page 2 - ([redacted], Chair/bed alarm on and functioning every shift - ([redacted]), [redacted] applied at bedside. Low bed. - ([redacted]), [redacted] (Residents have a picture of a [redacted] displayed outside their room to let staff know the resident is a risk [redacted] and needs to be checked on frequently.) A review of the facility's incident reports revealed the following [redacted] for Resident #1: - [redacted] A review of a nurse's note, dated [redacted], indicated an additiona[redacted] on [redacted]. A review of the quarterly Minimum Data Set (MDS) dated on [redacted] revealed Resident #1's cognition was [redacted]. The resident required extensive assistance for bed mobility, transfer, dressing, and toilet use. The resident required supervision and set-up during eating and physical help for part of bathing activity. The MDS indicated the resident was not steady moving from seated to standing position, moving on and off the toilet, and surface to surface transfer. The resident had no[redacted] or [redacted] and used a wheelchair. A review of the incident report for the fall on [redacted] indicated Resident #1 was found lying on the resident's back, alert and verbally responsive, on the floor next to a wheelchair. Resident #1 verbalized that he/she was trying to walk. Resident #1 had confusion at times. The	F 689	alarm findings to the Resident Safety Committee and to the Quality Assurance improvement Committee for a total of six months.	

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F 689	Continued From page 3	F 689		

report indicated the possible cause of the incident/accident as confusion and noncompliance. The action taken to prevent reoccurrence was to monitor Resident #1's whereabouts and a chair/bed alarm.

A review of a [redacted] note, dated [redacted], indicated the resident was able to transfer from bed to chair with one person assisting. A nurse aide reported increased weakness. A [redacted] chair was implemented. (The [redacted] was not added to the facility's care plan. A [redacted] with a wheeled [redacted].)

A review of the incident report for the fall on [redacted] indicated Resident #1 was found on the floor next to the bed by Certified Nursing Assistant (CNA) #10. It appeared Resident #1 had climbed out of bed over the side rails. The resident had [redacted] up. A [redacted] was noted to the [redacted]. The report indicated the bed alarm was not in place at the time of the fall. The possible cause of incident/accident was noted as, "Trying to climb OOB [out of bed." The action taken to prevent reoccurrence indicated, "Re-educating CNA [of] the importance of putting bed alarm on bed." Additional notes under actions taken indicated, "Bed put in low position - floor mats added - bed alarm add [sic]."

A review of a nurse's note, dated [redacted] indicated an additional fall on [redacted] at 9:40 PM. The resident got out of bed and claimed he/she slid. The resident was found sitting on the floor mat.

A review of the incident report for the [redacted]l on [redacted] indicated Resident #1 was found by a

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F 689	Continued From page 4 CNA who alerted the nurse that Resident #1 was on the floor, lying on the right side, in front of [redacted] chair. The RN supervisor was called to assess the resident. Upon assessment, a [redacted]. A [redacted] was noted near the [redacted], with [redacted] appropriately [redacted] noted to the [redacted] m. The possible cause of incident/accident was, "Attempting to get up to walk." The actions taken to prevent reoccurrence indicated, "Brought resident out to nurse's station to be monitored closely." An additional note in the incident report indicated the [redacted] program was added on [redacted] A review of the [redacted] risk evaluation dated on [redacted] revealed that Resident #1 had a score of [redacted] ([redacted]). A review of the incident report for the fall on [redacted] indicated Resident #1 was found sitting on the floor mat beside the resident's bed. The incident report indicated that Resident #1 fell from the [redacted] chair. No injuries noted. The action taken to prevent occurrence indicated that staff were to monitor Resident #1. The possible cause of incident/accident indicated "Resident seems to [have] slide [sic] or climb out of the [redacted] [sic] chair." The action taken to prevent reoccurrence was "Staff to monitor resident." The incident report indicated the bed alarm was on, but the resident fell from the chair. The chair alarm was not checked on the report as being in place at the time of the fall. The floor mat was in place. No new fall interventions were implemented for Resident #1. A review of the incident report for the fall on [redacted] at 7:30 PM indicated Resident #1 was	F 689		

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F 689	Continued From page 5	F 689		

found lying on the resident's left side beside the bed on the floor mat, and the bed was in the lowest position. The report indicated the resident fell from the chair. A [redacted] was noted to the [redacted]. The possible cause of incident/accident was, "Resident showed signs of confusion saying [he/she] wants to go home." The action taken to prevent reoccurrence was, "Put on a frequent watch or placing resident in a [redacted] [sic] chair and seat by the nursing station." The section of the report to indicate if alarms were in place was blank. There was also no written narrative to indicate if the alarms were in place. The intervention to put the resident on a frequent watch or place the resident in a [redacted] chair and seat at the nursing station was not added to the care plan.

A review of a "Nursing assistant fall monitoring" form for the incident on [redacted], revealed CNA #1 indicated that she saw Resident #1 after dinner sitting in the [redacted] chair at approximately 7:00 PM. CNA #1 indicated that no alarm was in place and the alarm was not sounding at the time of incident. CNA #1 was counseled.

A review of a nurse's notes written by LPN #4 (no longer employed at the facility) on [redacted] revealed Resident #1 was found lying on the resident's left side on the floor by the bed. A [redacted] The resident was able to move all extremities.

A review of the nurse's notes written by Registered Nurse (RN) #5 on [redacted] revealed Resident #1 was seen and examined. The resident was noted to be lying on the resident's left side on the floor mat. A small

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F 689	Continued From page 6	F 689		

amount of blood was noted at [redacted] to the [redacted]. The resident denied pain, and there was no loss of consciousness. The resident was noted to be [redacted]. The affected area was cleaned, and treatment was initiated. The resident was transferred back to the [redacted] chair with 3 persons assisting. Resident #1 remained on fall precautions.

A review of the [redacted] nurse's notes written by Registered Nurse (RN) #3 on [redacted] revealed the nurse received a call from the facility last evening reporting that Resident #1 was found on the floor at bedside, with a [redacted] to [redacted]. The [redacted] note indicated the resident was lying in bed supine, [redacted]. Recommendations were made to [redacted] to [redacted].

A review of Resident #1's [redacted] report dated on [redacted] revealed there was a [redacted]. The [redacted]. The conclusion was an [redacted].

A telephone interview on 07/15/2021 at 11:54 AM with the RN #3 [redacted]) indicated that Resident #1 had [redacted] and was a [redacted] RN #3 indicated that RN #5 called and said Resident #1 fell and [redacted], and there was a small amount of blood. RN #3 indicated that the fall was on [redacted], and she came in on the following [redacted] and saw Resident #1. RN #3 indicated that Resident #1's [redacted] and the resident

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F 689	Continued From page 7	F 689		

was [redacted] RN #3 indicated she ordered an [redacted]. RN #3 indicated that the fall could have been avoided because Resident #1 was at [redacted] and the resident's room was at the end of the hall. RN #3 further indicated that Resident #1's family member did not want the resident sent out of the hospital after the [redacted] on [redacted] RN #3 indicated that Resident #1's family wanted [redacted] management and comfort measures for the resident. RN #3 indicated that [redacted] initiated the [redacted] chair when Resident #1 was put on [redacted]

During an interview on 07/15/2021 at 4:09 PM, Certified Nursing Assistant (CNA) #1 stated that she found Resident #1 on the floor and notified the nurse. CNA #1 indicated Resident #1 would at times unplug the chair alarm. CNA #1 indicated she remembered feeding Resident #1 dinner and she thought Resident #1 fell from the [redacted] chair. CNA #1 further indicated that Resident #1 would get up unassisted. After family visits, Resident #1 would become agitated and want to go home. CNA #1 indicated that she was counseled for not making sure the chair alarm was in place during the fall on [redacted]

During an interview on 07/15/2021 at 4:31 PM with RN #5, she stated she assessed Resident #1, and the resident did not [redacted] and was able to move [redacted] after the fall.

During an interview on 07/15/2021 at 4:35 PM with LPN #6, he indicated Resident #1 was [redacted] and was [redacted]. LPN #6 further indicated the resident had bed and chair alarms. LPN #6 indicated Resident #1 was seated in a [redacted] chair near the nurses' station

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	315340	A. BUILDING _____ B. WING _____	C 07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

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F 689	Continued From page 8	F 689		

at times. LPN #6 stated the resident was in a low bed and would still try to get up but was easily redirected.

During an interview on 07/16/2021 at 11:24 AM with LPN #7, she indicated she did not recall talking to Resident #1's family member, and to her knowledge it was agreed by Resident #1's family, [redacted] Nurse #3, and the MD that Resident #1 would not go to the hospital and would instead be on[redacted] management. LPN #7 indicated that Resident #1 had a [redacted] at home.

During an interview on 07/16/2021 at 2:50 PM with LPN #2, she indicated she was made aware that Resident #1 had a fall, and [redacted] Nurse #3 ordered the[redacted] LPN #2 indicated [redacted] Nurse #3 reported that when she moved Resident #1's [redacted] on the next day, Resident #1 [redacted]

During an interview on 07/16/2021 at 11:44 AM with Resident #1's MD, he indicated he was very familiar with Resident #1 prior to coming to the nursing home. The MD indicated Resident #1 fell several times at home, did not eat well, and the resident's [redacted]. The MD further indicated Resident #1's health had declined due to [redacted] The MD said with [redacted] in [redacted], the resident's health further declined. The MD stated the [redacted] nurse recommended [redacted] and just [redacted] management and [redacted] measures due to the resident having all the other medical conditions. The MD agreed with [redacted] Nurse #3 and Resident #1's family member [redacted] management. The MD indicated Resident #1's

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F 689	Continued From page 9	F 689		

family member said no surgery. The MD stated that with Resident #1's poor intake and other diagnoses, Resident #1 would probably not make it through the surgery. MD indicated Resident #1 continued to decline after the [redacted] and was not eating. The MD indicated probably the [redacted] could have been a contributing factor of Resident #1's death, along with advanced [redacted].

During an interview on 07/16/2021 at 3:44 PM, the Administrator indicated that Resident #1's fall on [redacted] was during COVID-19, and residents were kept in their rooms. The Administrator indicated that staff were constantly checking on residents. The Administrator further indicated that the facility currently met on falls daily. She indicated it was hard to determine causal factors for residents who cannot verbalize what they were trying to do prior to the fall.

During an interview on 07/16/2021 at 4:00 PM, the Director of Nursing (DON) revealed that her employment started at the facility on [redacted] after the resident's falls.

A review of the facility's Fall Management Policy, dated June 2021, read in part,
Procedure:
b) Implement a plan of care which promotes maximum safety from falls, yet maintaining the resident's autonomy, dignity, and ability to function at his/her highest practicable physical, mental, and psychological level.

2. When a resident experiences a fall:
a) An Accident and Incidence Report shall be completed by the charge nurse.
b) The Resident Safety Committee shall evaluate each resident following a fall for progression of

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F 689	Continued From page 10 interventions. c) Fall interventions may include: low beds, half side rails, eye glasses, lap buddies, rest periods, reclining geriatric chair, supportive footwear and/or slipper socks, monitoring for orthostatic hypotension, positioning devices, pain management, food/hydration, mobility aids, toileting programs, reassurance, activity programs, optimal lighting, ambulation program, maintenance of communication with family/friends, accessible call lights, use of bedside commode, varied sitting locations, physical examination by attending physician or consulting physicians as needed, screen for use of wander guard alarm, and medications for mood/behavior problems. 3. Those residents assessed at high risk will be in the [redacted] Program. 4. The Interdisciplinary Care Team shall monitor for any indicators of increased falls, examining possible causative factors and then implementing a plan of care to eliminate these factors. 5. The Interdisciplinary Care Team and Falls Team will also note a reduction in the frequency of falls. Incidents and Accidents - Investigating and Recording a) The Resident Safety Committee shall evaluate incident reports and review falls for additional recommendations. b) Representation on the Resident Safety Committee shall include, but is not limited to, nursing, rehabilitation, administration, recreation, and social services departments. c) The committee shall establish a meeting schedule based upon need and meet at least once a week. d) The Medical Director will review all Incidents and Accidents Reports, including those with no	F 689		

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F 689	Continued From page 11 injury. New Jersey Administrative Code § 8:39- 5.1(a)	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ147243 Based on record review, interviews, and facility policy review, it was determined that the facility failed to ensure a resident was properly assessed for bed rails for 1 (Resident #1) of 1 resident reviewed for bed rails. Resident #1 had [redacted] bed rails. Resident #1 was identified as a [redacted] and climbed over the bed rails, fell, and sustained a [redacted]	F 700	1.Resident #1 is expired. Bed rail assessments, care plans, and physician orders will be reviewed for all residents to ensure the that the bed rail assessment is completed and that the bed rail policy is being followed. 2. All long-term care residents may be affected by not following the bed rail policy. Bed rail assessments will be	9/21/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE GARDENS LIVING CENTER	22 WEST JIMMIE LEEDS ROAD GALLOWAY TOWNSHIP, NJ 08205

(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
F 700	Continued From page 12 Findings included: 1. Resident #1 was admitted to the facility on [redacted] with diagnoses that included history of [redacted]. Resident #1 was no longer in the facility. Resident #1 had a fall care plan, originated on [redacted], that indicated the resident was at risk for [redacted], and use of [redacted] medications. A care plan intervention as of [redacted] indicated [redacted] rails on [redacted] of the bed as a fall intervention. A review of Resident #1's physician's orders dated [redacted] revealed an order for full bed rails on both sides of the bed for position/enabler and safety. A review of the quarterly Minimum Data Set (MDS) dated [redacted] revealed Resident #1's cognition was [redacted]. The resident required extensive assistance for bed mobility, transfer, dressing, and toilet use. The resident required supervision and set-up during eating, and physical help for part of bathing activity. The MDS indicated the resident was not steady moving from seated to standing position, moving on and off the toilet, and surface to surface transfer. The resident had no upper or lower extremity impairment and used a wheelchair. The MDS indicated side rails were "not used."	F 700	reviewed for all residents and updated as appropriate and any changes will be reflected on the resident□'s care plans. All residents will have a bed rail assessment completed upon admission and reassessed quarterly. Consent will be reviewed with the resident and/or responsible party and will be reassessed and renewed annually. 3.Policy and procedures for bed rails reviewed and revised. Nursing and Maintenance Department in-serviced by DON or her designee on the Bed Rail Policy and Procedures. Physician's orders will be written to include the specific type of bed rails used. Physicians orders obtained for all bedrail placements. Care plans and nursing Kardex will be updated as to what specific bed rails are used. Resident Safety Committee will reassess bed rail use after any fall. Annual care plan meetings will include a consent for use of bed rails to be reevaluated, continued, or a new bed rail initiated per facility policy. 4.DON or his/her designee to audit and review side rail use monthly during resident safety committee meeting. Side rail use added to a spreadsheet to include resident name, room number, and bed rail type to track for six months DON and/or designee will report the findings to the resident safety committee and Quality Assurance Improvement Committee for six months.	

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F 700	Continued From page 13 A review of Resident #1's admission bed rail assessment, dated on [redacted], indicated the bed side rail rationale for potential use as, "Medical Condition (specify)," however, no medical symptom was documented. The area to "Discuss Medical Symptom(s) on the form was blank. The assessment form indicated Resident #1 had poor safety awareness. The section on the bed rail assessment form, titled, "Will the bed rail enable the resident to achieve his/her highest level of functional independence in bed mobility?" was blank. Resident #1's family member gave verbal consent for use of the [redacted] rails. Under the form section for, "Alternatives attempted prior to use of side rails," the form was blank. A review of Resident #1's bed rail assessment, dated [redacted] and [redacted] indicated the facility document a medical symptom of poor cognition and safety awareness. The assessment form indicated that Resident #1 had [redacted] The assessment form indicated Resident #1 used the [redacted] rails for turning side to side, moving self up and down in bed, and pulling and holding self over. The assessment indicated Resident #1 used the [redacted] rails to aid in safe entry into bed and aid in safe exiting from bed. Side rails were recommended for safety and as an enabler. There were no signatures documented for the nurse, resident representative, or verbal permission/consent. Under the section, "Alternatives," the facility documented that alternatives had been discussed with the resident and the resident's representatives, however under the section, "Alternatives attempted prior to use of side rails," the facility did not document the side rail alternatives and how any alternatives failed to meet the resident's assessed needs.	F 700		

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F 700	Continued From page 14 A review of a [redacted] note, dated [redacted], indicated the resident was able to transfer from bed to chair with one person assisting. A review of the incident report for the fall on [redacted] indicated Resident #1 was found on the floor next to the bed by Certified Nursing Assistant (CNA) #10. It appeared Resident #1 had climbed out of bed over the side rails. The resident had [redacted] side rails up. A [redacted] was noted to the [redacted]. The report indicated the bed alarm was not in place at the time of the fall. The possible cause of incident/accident was noted as, "Trying to climb OOB [out of bed]." A review of a nurse's note, dated [redacted], indicated an additional fall on [redacted] at 9:40 PM. The resident got out of bed and claimed he/she slid. The resident was found sitting on the floor mat. An interview on 07/15/2021 at 4:09 PM with the CNA #1 indicated that Resident #1 had [redacted] rails up when in bed. An interview on 07/16/2021 at 1:45 PM with the Minimum Data Coordinator (MDS Nurse) revealed that Resident #1 was [redacted] and [redacted] and needed both [redacted] side rails up. The MDS Nurse indicated that the [redacted] side rails did not restrict Resident #1's freedom of movement. An interview on 07/16/2021 at 3:44 PM with the Administrator revealed that the facility tried to use the least restrictive restraint if the facility had to use one. The Administrator indicated that she did not feel that the [redacted] side rails were a restraint for Resident #1. The Administrator further indicated that Resident #1's family member wanted the	F 700		

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F 700	Continued From page 15 resident to have [redacted] full side rails. An interview on 07/16/2021 at 4:00 PM with the Director of Nursing (DON) revealed that her employment started at the facility on [redacted]. The DON was unable to locate an order for the [redacted] side rails to be discontinued. A review of the "Restraint Management: Bed Rails Policy," dated 05/2015 revealed in part, Bed rails are considered a physical restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving the bed). The use of bed rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. The purpose for this procedure is to prevent resident injury and serve as an enabler for the resident. 1. Bed rails may be used to assist in mobility and transfer of residents. 2. An assessment must be made to determine the resident's symptoms for using bed rails. When used for mobility or transfer, an assessment should include a review of the resident's: a) Bed mobility. b) Ability to transfer between positions, to and from bed or chair, to stand and toilet. 3. If the resident uses the rails as an enabler for returning, reposition, or getting out of bed, then the rail is not considered a restraint. 4. The use of bed rails as an assistive device must be addressed in the resident's care plan. 5. Less restrictive interventions that the Home might incorporate in care planning include: a) Providing rehabilitation to enhance abilities to stand safely and to walk. b) Placing the bed lower to the floor. c) Equipping the resident with a device that monitors attempts to arise.	F 700		

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F 700	Continued From page 16	F 700		

d) Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or
e) Furnishing visual and verbal reminders for residents who are able to comprehend this information.
6. The resident would be checked frequently for safety.
7. Bed rails with padding may be used to prevent resident injury in situations of controllable movement disorders.
8. The Home's staff will use judgement in assessing the resident's risk for injury.
9. For residents who have been restrained by bed rails, the process to reduce the use of bed rails as restraints should be systematic and gradual (e.g., lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell).

A review of the facility's Fall Management Policy, dated June 2021, read in part,
Procedure:
b) Implement a plan of care which promotes maximum safety from falls, yet maintaining the resident's autonomy, dignity, and ability to function at his/her highest practicable physical, mental, and psychological level.

2. When a resident experiences a fall:
c) Fall interventions may include: low beds, half side rails, eye glasses, lap buddies, rest periods, reclining geriatric chair, supportive footwear and/or slipper socks, monitoring for orthostatic hypotension, positioning devices, pain management, food/hydration, mobility aids, toileting programs, reassurance, activity programs, optimal lighting, ambulation program, maintenance of communication with family/friends, accessible call lights, use of

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F 700	Continued From page 17 bedside commode, varied sitting locations, physical examination by attending physician or consulting physicians as needed, screen for use of wander guard alarm, and medications for mood/behavior problems. New Jersey Administrative Code § 8:39- 5.1 (a)	F 700		