DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING _____ B. WING _____	C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH STREET ALCESTER, SD 57001

(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 An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 6/6/23. Areas surveyed included bedrails and accident hazards. Alcester Care and Rehab Center, Inc was found not in compliance with the following requirement: F700.	F 000		
F 700 SS=H	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on incident report review, interview, observation, record review, and policy review, the provider failed to:	F 700	Unable to change the outcome of the deficient practice for failure to measure bedrail safety zones for residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11. DON or designee will obtain informed consent for the use of bedrails for resident 3. DON or designee will update residents 3, 8, 10, and 11 care plans to reflect use of bed rails. DON or designee will obtain physician orders for the use of bedrails for residents 1, 2, 3, 5, 6, 7, 8, 9, 10, and 11. ** TM 06/19/2023 Maintenance Director or designee will update all bedrail zone assessment for residents utilizing bedrails currently.**** TM 06/19/2023 Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for side rails and update measurement safety zones on 06/15/2023. *** TM 06/19/2023 DON or designee will provide education to all staff on 06/19/2023 and 06/23/2023. * TM 06/19/2023 DON or designee will perform audits on all side rails to ensure all assessments are completed with accuracy once a week for four weeks and once per month for two more months.	06/24/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tiffany Mills

TITLE: Administrator

(X6) DATE: 06/19/2023 ~~6/15/2023~~

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

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F 700	Continued From page 1 *Properly measure the bedrail safety zones for eleven of eleven residents with bedrails (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11), which resulted in resident injury for one of one sampled resident (11) when his head got wedged in an area of the bedrail that had not been measured. *Complete assistive device assessments for three of eleven sampled residents with bedrails (1, 3, and 9). *Obtain informed consent for the use of a bedrail for one of eleven sampled residents (3) with bedrails. *Update care plans to reflect the use of bedrails for four of eleven sampled residents (3, 8, 10, and 11). *Obtain physician's orders, per the provider's policy, for the use of bedrails for ten of eleven sampled residents with bedrails (1, 2, 3, 5, 6, 7, 8, 9, 10, and 11). Findings include: 1. Review of the provider's 6/2/23 "Healthcare Online Self Reporting" incident report submitted to the South Dakota Department of Health revealed: *On 5/28/23 at 6:10 a.m., resident 11 was heard moaning from his room by facility staff. *Upon entering his room, staff found "[resident 11's] face into side of bed frame/side rail ... He was on his knees. His head was between the bed frame and side rail, face down against the railing." *"[Resident 11's] mouth was bleeding and tooth was crooked." *"[Resident 11] was assisted out of the position with the assist of three staff, with his neck being stabilized during the change of position to the floor." *"[Resident 11] was laid down on his back with his neck being stabilized."	F 700	DON or designee will present findings from these audits monthly for three months at the QAPI meetings for review until the QAPI committee advises to discontinue monitoring. *Education will include assistive device assessments, bedrail zone measurements, care plan updating, the need for physician orders, and overall maintenance of bedrails. **DON or designee will complete assistive device assessments for residents 1, 3, and 9. ***Policy will include which zones will be measured on the beds and will include the measurement expectations. **** Maintenance Director will be reeducated on how to properly assess the bed rail zones in accordance to our updated policy, and how to appropriately fill out the assessment form.	TM 06/19/2023 TM 06/19/2023 TM 06/19/2023 TM 06/19/2023

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F 700	Continued From page 2 *The call light was found near him, but resident 11 had not turned it on. *He was "talkative, and in a good mood" with "no complaints of pain." *"There was no discoloration to his face and he did have a cut to his chin; this cut on his chin was slightly bleeding and was cleaned and gauze was held on the area." *"[Resident 11] stated he was trying to sit up at side of bed, and that his mouth was open when he fell." *He was transported to a local emergency room for evaluation. -Assessments from the emergency room indicated "no significant injuries ...other than a broken tooth." *The provider reeducated resident 11 on "using his call light to call for and then wait for assistance before trying to get up and or out of bed." *Resident 11 declined the provider's offer to have him evaluated by a dentist. *He had "no complaints of pain or difficulty with eating and has continued to eat his normal diet." *The provider gave resident 11 a different bed, mattress, and different set of half bedrails. 2. Interview on 6/6/23 at 10:30 a.m. with administrator A about resident bedrails revealed: *After resident 11's incident, they removed that set of bedrails from his bed. -They disposed of those bedrails by the time of the survey. *They had performed safety measurements on his bedrails prior to the incident. *She said, "Everything was within measurements, so I do not know how he got his head stuck." Interview on 6/6/23 at 10:38 a.m. with certified	F 700		

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nurse assistant/certified medication aide (CMA) E about resident 11's incident revealed:
*She and some other staff (licensed practical nurse (LPN) C and registered nurse (RN) F) had heard yelling coming from resident 11's room.
*When they entered the room, it looked like resident 11 was in a "praying position" with his knees on the floor and his head leaning off to one side.
*His call light was near him, but it had not been turned on.
*There was blood on his bed sheets and face.
*It took three staff members to help lift his head out from the bedrail.
*They used pillows to stabilize his neck.
*She stayed with resident 11 the entire time while the nurse manager called the ambulance.
*During the above-described process, CMA E said that resident 11 was alert and acting like his normal self.

Interview on 6/6/23 at 10:44 a.m. with LPN C about resident 11's incident revealed:
*She was conducting the morning shift report when they heard yelling.
*When she, CMA E, and RN F entered resident 11's room, he "looked like he was praying; his head was down."
*His head was lodged in between the bed frame and bedrail.
*They "gently lifted his head out of the wedged position."
-They stabilized his neck and head with a pillow as they lowered him to a laying position on the floor.
*There was blood on the bedrail and his bed sheets.
*When she assessed resident 11, she noted blood on his chin and mouth, swelling to the back

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F 700	Continued From page 4 of his head, and a broken crooked tooth. *She instructed CMA E to remain with resident 11 while she went to call an ambulance. *Resident 11 had not sustained any fractures. *He declined to go to a dentist to fix his broken tooth. 3. Interview on 6/6/23 at 10:59 a.m. with director of nursing/Minimum Data Set coordinator (DON) B about their process for assessing bedrails revealed: *When a new resident was admitted and received physical therapy (PT), PT generally recommended bedrails for assistance with repositioning in bed. -Most of their bedrails were used based on PT recommendations. *When she received a recommendation from PT for a resident to use bedrails, she would inform maintenance director D to install the bedrails according to the recommendation. *Maintenance director D would install the bedrails and perform his safety measurements to ensure it was installed properly. *She would then use the provider's "Assistive Device Assessment" to determine if the resident was able to use the bedrail safely and correctly to the reduce the risk of entrapment. -If a resident was deemed not safe to use the bedrail, she would refer the resident back to PT for further recommendations. *During her assessment, she obtained the consent from either the resident or their representative. *She would then obtain a physician's order for the bedrail and update the resident's care plan. *She reassessed the use of bedrails with each of the resident's Minimum Data Set (MDS) assessments.	F 700		

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-The MDS assessments were completed quarterly, annually, and any time a significant change occurred.
*She acknowledged that they had recently been cited on bedrails with their previous recertification survey (completed on 3/9/23), and part of their plan of correction was to complete the steps mentioned above.

Interview on 6/6/23 at 11:21 a.m. with maintenance director D about his role with installing resident bedrails revealed:
*He installed and removed bedrails when DON B requested.
*They used bedrails at the head of the bed (HOB), not at the foot of the bed.
*He used the provider's "Bed Rail Safety Assessment" to measure different zones in the bedrail, bed frame, and mattress to reduce the risk of entrapment.
*Prior to resident 11's incident, he was measuring zones one and three only.
-Refer to finding 13 for zone descriptions.
*As a result of the incident, he edited the "Bed Rail Safety Assessment" to include measurements for Zones 1, 2, 3, and 4.
-He removed Zones 5, 6, and 7 from the form.
-Resident 11 had gotten his head stuck in Zone 4.

4. Interview on 6/6/23 at 2:09 p.m. with resident 11 about his incident revealed:
*It happened early in the morning. He had just woken up, so he was still groggy and not fully awake.
*He rolled over to his left side in bed to get up.
*His knees slipped off the bed, and the rest of his body fell with.
*At that time, his head got stuck under the bedrail.

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F 700	Continued From page 6 *He stated he was stuck for about five to ten minutes before the staff heard his yells for help. -He was scared because he did not know how long it would take until someone found him. -He said he felt like he was stuck in the bedrail for a long time. *He bruised both sides of the back of his head and his upper neck. *His tooth was broken and bleeding. -That broken tooth had later fallen out completely. *After the incident, he received a new bed with a different set of bedrails. 5. Observations on 6/6/23 from 1:23 p.m. through 3:12 p.m. of each resident's room in the building revealed the following residents had bedrails: *Residents with half-bedrails to both sides of their bed included the following residents: 1, 4, 6, 8, 9, and 11. -Resident 11's bed had a metal tube sticking out of the left-side HOB wheel. -The tube appeared to not serve any purpose. -It had sharp edges. *Residents with a half-bedrail to one side of their bed included residents 2, 3, 5, 7, and 10. -Resident 10's bedrail was very loose upon physical inspection. -Resident 3 stated she mainly used the bedrail to clip her bed remote to, but at times she would use it to reposition herself. 6. Interview on 6/6/23 at 3:57 p.m. with DON B about their procedure for bedrails and resident 3's bedrail revealed she: *Acknowledged that she missed adding bedrail use on care plans for residents 3, 8, 10, and 11. -She indicated she updated all their care plans that day to reflect the use of bedrails. *Knew she had gotten faxes with physician's	F 700		

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orders for bedrails for some of the residents, but the orders had not been entered into the corresponding resident's electronic medical record and she could not locate the paper or scanned copies of their physician's orders.
*Confirmed there were no physician orders for the use of bedrails for residents 1, 2, 3, 5, 6, 7, 8, 9, 10, and 11.
*Confirmed that she knew resident 3 had the bedrail on her bed.
-Resident 3 had told her that she would only use it for storing her bed remote.
*Confirmed they had not completed the following for safe bedrail use:
-Assessed the resident using the provider's "Assistive Device Assessment."
-Measured the bed safety zones using the provider's "Bed Rail Safety Assessment."
-Obtained informed consent for the use of the bedrail.
-Updated the care plan indicating that resident 3 had the bedrail and what she was using it for.
-Obtained a physician's order for the use of the resident's bedrail.
*Acknowledged that they had been cited on inappropriate bedrail use during their previous recertification survey from 3/9/23.

7. Interview on 6/6/23 at 4:40 p.m. with administrator A and maintenance director D about their updated bedrail procedures revealed:
*As a result of their previous survey, they updated their bedrail policy and implemented the "Assistive Device Assessment" and the "Bed Rail Safety Assessment."
*Maintenance director D confirmed that prior to resident 11's incident, he had not been measuring the space between the edge of the bedrail and the bed frame, which was the zone that resident

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F 700	Continued From page 8 11 had gotten his head stuck. -Prior to the incident, he had misinterpreted the different bed safety zones and as a result had not been completely assessing each potential zone of entrapment for the residents with bedrails. --He said that the bed measurements diagram had zones two and four pointing to the foot of the bed, so he thought he did not need to measure those zones. -He was in the process of updating the "Bed Rail Safety Assessment" to include the relevant bed zones. 8. Review of resident 3's medical record revealed that the provider had not completed the following: *The "Assistive Device Assessment." *Measured areas of possible entrapment on the provider's "Bed Rail Safety Assessment." *Obtained an informed consent from the resident for the use of a bedrail. *Updated her care plan to reflect that she was using a bedrail. *Obtained a physician's order for the use of the bedrail. 9. Review of the provider's "Bed Rail Safety Assessment" revealed the assessment was missing measurements for the following residents: 1, 2, 4, 5, 6, 7, 8, 9, 10, and 11. *Resident 1: The form was dated 4/3/23. There were measurements for zones one, three, four, and six. There was a handwritten "NA" in the space for zone two measurements. There were no measurements for zone seven. There was no need for a zone five measurement because the provider was not using foot rails. *Residents 2, 5, 6, and 8: Their forms were dated 4/3/23. There were measurements for zones one, three, and four. There was a handwritten "N/A" in	F 700		

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the space for zone two measurements. There were no measurements for zones six and seven.
*Resident 4: The form was dated 6/2/23. There were measurements for zones one, two, three, and four. Zones six and seven had been removed from the form.
*Resident 7: The form was dated 3/22/23. There were measurements for zones one, two, three, six, and seven. There was a handwritten "No Footrail" for zone four, and "N/A" for zone five.
*Resident 9: The form was dated 5/19/23. There were measurements for zones one, two, three, and four. Zones six and seven had been removed from the form.
-Zone four was measured at "2 3/4" inches, which is larger than the recommended distance of "2 3/8 inches" or less.
-For the question, "Are there any gaps of recommended space or larger when the resident is in the bed?" the box for "yes" was checked.
-Below the question, the form read, "If Yes, the resident is at risk for being trapped."
-In the "Analysis(Assessment)" section, there was a handwritten "Good."
*Resident 10: The form was dated 4/3/23. There were measurements for zones one and three. There were handwritten notes of "N/A" for zone two, and "Even [with] mattress" for zone four. There were no measurements for zones six or seven.
*Resident 11: There were two forms dated 4/3/23 and 5/29/23.
-On the form from 4/3/23, there were measurements for zones one and three. There were handwritten notes of "NA" for zone two, and "N/A" for zone four. There were no measurements for zones six or seven.
-On the form from 5/29/23 (the day after resident 11 got his head stuck in zone four of his bed),

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F 700	Continued From page 10 there were measurements for zones one, two, three, and four. There were no measurements for zones six or seven. 10. Review of the resident's care plans revealed the following residents had no mention of bedrails on their care plans: Residents 3, 8, 10, and 11. 11. Review of the resident's physician's order revealed the following residents had no physician's orders for bedrails: 1, 2, 3, 5, 6, 7, 8, 9, 10, and 11. 12. Review of the provider's "Assistive Device Assessment" forms for residents 1 and 9 revealed: *Both forms were completed on 4/4/23. *Questions 5, 6, and 7 had not been answered. -The section stated, "Resident can demonstrate proper use of the device when:" --"5. Turning from side to side? Yes, No, Not applicable." --"6. Rising to sitting position? Yes, No, Not applicable." --"7. Transfer into and out of bed? Yes, No, Not applicable." 13. Review of the provider's undated "Bed Inspection and Bed Rail Policy" revealed: *"Policy: It is the policy of this facility to identify and reduce safety risks and hazards commonly associated with bedrail use." *"Procedure: Identifications of risks and benefits pertaining to bedrails, use bedrails, mattresses, and bed frame." *Under the "Resident Assessment" section of the policy: -"B. Upon admission, readmission [or] change [of] condition, residents will be screened to	F 700		

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F 700	Continued From page 11 determine: --"1) Level of independence with bed mobility" --"2) Bed comfort level" --"3) If bed meets [manufacturer's] recommendations and specifications pertaining to resident height and weight" --"4) Assess the need for special equipment or accessories" ---"i. [Assess] the resident to identify appropriate alternative prior to installing bed rails" ---"ii. Assess the resident for risk of entrapment from bed rails prior to installation" ---"iii. [Review] the risk and benefits with resident and resident representative" ---"iv. Obtain informed consent" --"5) The facility will document ongoing need for the use of a bedrail quarterly" --"6) Obtain physician order for medical symptom assessed for need for bed rail use" --"7) Resident care plan will include use of bed rails as assessed." --"8) The facility will fill out the '[Facility name] Assistive Device Assessment' upon bed rail implementation." *Under the "Equipment Management and Maintenance" section of the policy: -"A. When installing or maintaining bedrails, the maintenance department staff will follow the [manufacturer's] recommendations and specifications, or provide another bed or appropriate alternative in accordance with individual bed inspections." -"B. The maintenance department will conduct annual inspection of all bed frames, mattresses, and bedrails, as part of a regular maintenance program to identify areas of possible entrapment." --"a. When bedrails and mattresses are used and purchased separately from the bed frame, the	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING _____ B. WING _____	C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH STREET ALCESTER, SD 57001

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F 700	Continued From page 12	F 700		

facility will select equipment such as bed rails, mattresses and bedframes that are compatible."
--"b. The interdisciplinary team will identify resident-specific bed adaptations and pertinent safety risks on the resident care plan."
*At the bottom of the second page of the policy, there was a diagram of a standard nursing home bed which included a headboard, a footboard, and the seven zones of bedrail safety as recommended by the Food and Drug Administration (FDA).
-"Zone 1: Within the Rail. Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The recommended space should be less than 120 mm [millimeters] (4 3/4 inches), representing head breadth."
--On the diagram, the area pointing to Zone 1 was on the bedrail at the HOB.
-"Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support. Preventing the head from entering under the rail would most likely avoid neck entrapment in this space. FDA recommends this space be small enough to prevent head entrapment, less than 120 mm (4 3/4 inches).
--On the diagram, the area pointing to Zone 2 was the bedrail towards the footboard.
-"Zone 3: Between the Rail and the Mattress. FDA is recommending a dimensional limit of less than 120 mm (4 3/4 inches) for the area between the inside surface of the rail and the compressed mattress."
--On the diagram, the area pointing to Zone 3 was on the bedrail at the HOB.
-"Zone 4: Under the Rail, at the Ends of the Rail. FDA recommends the dimensional limit for this space also be less than 60 mm (2 3/8 inches)."

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F 700	Continued From page 13 --On the diagram, the area pointing to Zone 4 was the bedrail towards the footboard. -"Zone 5: Between Split Bed Rails. This zone occurs when partial length head and foot side rails (split rails) are used on the same side of the bed. The space between the split rails may present a risk of either neck entrapment or chest entrapment between the rails if a patient attempts to, or accidentally, exits the bed at this location." --On the diagram, the area pointing to Zone 5 was in the middle of the bed, in between the bedrails at the HOB and foot of the bed. -"Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board. This space may present a risk of either neck entrapment or chest entrapment." --On the diagram, the area pointing to Zone 6 was at the HOB. -"Zone 7: Between the Head or Foot Board and the Mattress End. This space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosened head or foot boards." --On the diagram, the area pointing to Zone 7 was at the HOB.	F 700		