POC Reviewed and accepted 36904 for 27785

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

36904 4/25/22

PRINTED: 03/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint number: CA00770972 Representing the Department: Health Facilities Evaluator Nurse: 27785 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were identified for the complaint number: CA00770972.	F 000		
F 689 SS=D	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: Based on observation, interview, and record review, the facility failed to follow one (Resident 1) of three sampled resident's assessment to ensure safety. Resident 1, who was assessed as a two-person assist for bed mobility, fell from bed while being turned to his side by Certified Nurse Assistant 1 (CNA 1). This had the potential to have resulted in a more	F 689	F- 689 Corrective action for resident found to have been affected by this deficiency: Resident 1 was discharged home on 2/26/2022. Corrective action for residents that may be affected by this deficiency: All residents who need 2-person assistance with bed mobility have the potential to be affected by this practice. All residents who need 2-person assistance with bed mobility were reviewed, and no issues or concerns were identified. IDT and Nursing staff will be in-serviced on how to care of residents who need 2-person assistance with bed mobility. For residents who need 2-person assistance with bed mobility, a sticker will be placed as an identifier by the name plate outside of their room.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE RN / DON | (X6) DATE 4/01/2022

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.

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

PRINTED: 03/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050360	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 689	Continued From page 1 than minimal injury for Resident 1 due to the fall. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on 1/21/2022. Resident 1's diagnoses included complete traumatic amputation (the loss of a body part occurred as the result of an accident or injury) of the left lower leg at a level between knee and ankle, generalized muscle weakness, abnormal posture (rigid body movements and chronic abnormal positions of the body), and morbid (severe) obesity (abnormal or excessive fat accumulation that presents a risk to health). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/25/2022, indicated Resident 1 had the ability to make self understood and understand others. The MDS indicated Resident 1 required extensive assistance (resident involved in activity, staff provide weight-bearing support) from staff, with two plus persons physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). The MDS further indicated that Resident 1 did not have any history of falls. A review of Resident 1's Fall Risk Evaluation dated 1/27/2022 indicated Resident 1 had a medium risk for fall, and required use of assistive devices (cane, walker, wheelchair) for gait, balance, and/or ambulation. A review of Resident 1's care plan titled, "At Risk for Falls," initiated on 1/21/2022, and updated	F 689	Measures that will be put into place to ensure that this deficiency does not occur: IDT, on their guardian angel rounds, will check if interventions are in place for their assigned residents and will update as needed. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: DSD will monitor CNAs who are assigned to residents who need 2-person assistance with bed mobility on a daily basis x 1 month, then weekly x 3 months. DON / Designee will randomly check at least 2 residents who need 2-person assist with bed mobility to ensure compliance on a weekly basis x 3 months. Findings will be reported to the QA Committee. Date of completion April 15, 2022	

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
	056369	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 689	Continued From page 2 when resident had an actual fall while receiving ADL care on 1/27/2022 , listed interventions including side rails as ordered (1/21/2022), and provide safety education/fall prevention techniques to resident and staff member (1/28/2022). A review of Resident 1's nursing progress notes by Licensed Vocational Nurse 1 (LVN 1), dated 1/27/2022, at 10:38 AM, indicated the following, "5:30 AM Pt (patient/resident) noted yelling. Pt found on the floor sitting next to bed. Pt alert and able to make needs known. Asked pt what happened pt stated he was trying to turn and slid out of bed. Explained to pt to use call light when needing help. Pt understood. Body check done. No skin issues noted. Pt stated right shoulder pain. Offered medication pt said no. Neuro checks done. MD (physician) notified with no new orders. Responsible party notified. Check on pt at 6:15 AM pt noted resting in bed comfortably. Pt handled gently during nursing care. All needs met. Call light within reach." A review of Resident 1's Change of Condition (COC) Evaluation form, dated 1/27/2022, indicated that Resident 1 was found on the floor in the morning on 1/27/2022. The COC evaluation indicated Resident 1 had an acute pain of 5 (moderate pain) using the 0-10 pain scale assessment. The COC evaluation indicated there were no changes on the resident's mental status, functional status, behavioral evaluation, respiratory evaluation, skin evaluation, and neurological evaluation. The COC evaluation also indicated that the physician and family were notified regarding the change of condition on 1/27/2022 at 5:30 AM. This COC evaluation was completed and e-signed by LVN 1.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 689	Continued From page 3	F 689		

A review of Resident 1's, "Left Shoulder Radiology Results Report," dated 1/27/2022 at 18:34 (6:34 PM), and reported on 1/27/2022 at 19:56 (7:56 PM), indicated a "Normal left shoulder," with no changes indicating fracture or dislocation.

A review of Resident 1's, "Spine and Thoracic (Chest) Radiology Report," dated 1/27/2022 at 18:34 (6:34 PM) and reported on 1/27/2022 at 19:56 (7:56 PM), indicated, "Minor degenerative changes (cushioning in the spine begins to wear away, most common in older adults)."

A review of Resident 1's PT (Physical Therapy) Evaluation and Plan of Treatment form with certification date of 1/21/2022 to 2/17/2022, indicated a goal for resident to improve ability to roll from lying on back to left and right side and return to lying on back with partial/moderate assistance to participate in self-care activities and participate in activities of daily living. The target date for this goal was 2/3/2022. The PT evaluation form indicated Resident 1's baseline ability to roll from left and right, dated 1/21/2022, was substantial/maximal assistance (2 person)

During an interview with the Director of Nursing (DON) on 1/28/2022, at 12 PM, the DON stated, they report fall incidents only if it resulted to major injury.

During a concurrent observation and interview with Resident 1 on 1/28/2022, at 12:30 PM, Resident 1 was observed in bed, awake and alert. The head part of resident's bed was elevated and a lunch tray was on top of over the bed table. Bilateral half side rails were up, and no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 689	Continued From page 4 other fall precaution was observed. There were no signs of injury noted during skin observation. Resident had no roommate. Resident 1 stated, CNA 1 was changing his linen when he fell. Stated CNA 1 told him to roll on his side while she was tucking the linen under him. CNA 1 pushed him too hard and that's how he fell. CNA 1 ran outside to get help and came back with three other staff. Resident 1 stated, the side rails was not enough to help him because it was too small for him. Resident 1 stated, he did not consider it as physical abuse and it was not intentionally done to hurt him but nurse should have been careful. Resident 1 stated, he still has some pain on his shoulder and back and said that they took six views of X-ray yesterday. During a telephone interview with LVN 1 on 3/7/2022 at 4:05 PM, LVN 1 stated, what happened was CNA 1 was changing Resident 1 when he fell while turning to his side. CNA 1 was by herself changing the resident. Resident 1 was a one-person assist with bed mobility based on what resident verbalized he could do and what he was able to show them. LVN 1 stated, this was not based on Resident 1's MDS assessment. Stated they put him back to bed after resident told them he was fine, and notified his family and physician. During a telephone interview with CNA 1 on 3/9/2022, at 11:09 AM, CNA 1 stated, around 12 midnight, right after her shift started she went to Resident 1's room and introduced herself and told him she was going to be his nurse for the night shift. CNA 1 stated, she noted Resident 1 needed to be changed. She asked him if he could turn by himself and Resident 1 stated, yes. That was why she did not ask for help from	F 689		

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

PRINTED: 03/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 689	Continued From page 5 another staff. CNA 1 stated, during their daily huddle at the start of their shift it was endorsed to her that Resident 1 was a two-person assist because of his size, and that she should ask other staff if she needed help. CNA 1 stated, she knew Resident 1 was a two-person assist but she did not ask for help because the resident told her that he is able to turn by himself. CNA 1 stated, she was helping Resident 1 to turn to his side when resident fell. She yelled for help and the two night shift charge nurses and another CNA came in the room and help resident back to bed. She stated that the charge nurses assessed the resident for injury before they placed him back to his bed and there was no injury noted.	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'	F 700	F- 700 Corrective action for resident found to have been affected by this deficiency: Resident 1 was discharged home on 2/26/2022 . Corrective action for residents that may be affected by this deficiency: All residents who use side rails may be affected by this practice. All new admissions will have appropriate alternative interventions prior to the use of side rails and a safety assessment will be done if interventions fail and side rails are needed. IDT and Nursing staff will be in-serviced regarding the use of other interventions prior to utilizing side rails. Residents using side rails will be reassessed by MDS following the MDS schedule for possible alternative interventions aside from side rails.	

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

PRINTED: 03/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 6 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to document that alternative interventions were used and safety assessment were done for one of three sampled residents (Resident 1) before using side rails (bed rails, a metal or plastic bars positioned along the side of a bed to aide resident bed mobility). This had the potential risk to result to side rail related injury to the resident. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on 1/21/2022. Resident 1's diagnoses included complete traumatic amputation (the loss of a body part occurred as the result of an accident or injury) of the left lower leg at a level between knee and ankle, generalized muscle weakness, abnormal posture (rigid body movements and chronic abnormal positions of the body), and morbid (severe) obesity (abnormal or excessive fat accumulation that presents a risk to health). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/25/2022, indicated Resident 1 had the ability to make self understood and understand others. The MDS indicated Resident 1 required extensive assistance (resident involved in activity, staff provide weight-bearing support) from staff, with two plus persons physical assist for bed mobility (how resident moves to and from lying position,	F 700	Measures that will be put into place to ensure that this deficiency does not recur: All side rails will be removed from empty beds and all new admissions will be provided with appropriate alternative interventions, and a safety assessment will be done prior to installing a side rail. MDS will monitor if appropriate alternative interventions are in place and a safety assessment is done prior to installing a side rail. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: DON / Designee will randomly check 2 residents on a weekly basis to ensure interventions are in place prior to the use of siderails. Findings will be reported to the QA Committee. Date of completion April 15, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 7 turns side to side, and positions body while in bed or alternate sleep furniture). The MDS further indicated that Resident 1 did not have any history of falls. A review of Resident 1's Fall Risk Evaluation dated 1/27/2022 indicated Resident 1 had a medium risk for fall, and required use of assistive devices (cane, walker, wheelchair) for gait, balance, and/or ambulation. A review of Resident 1's care plan titled, "At Risk for Falls," initiated on 1/21/2022, and updated when resident had an actual fall while receiving ADL care on 1/27/2022 , listed interventions including side rails as ordered (1/21/2022), and provide safety education/fall prevention techniques to resident and staff member (1/28/2022). A review of Resident 1's physicians orders dated 1/21/2022, for ¼ side rails for positioning and ease in mobility as an enabler. A review of Resident 1's Bed Rail Safety Evaluation indicated this evaluation was done on 1/28/2022, after Resident 1 fell on 1/27/2022. This evaluation form also indicated that there was no documentation for any alternative interventions attempted prior to the use of the side rails During a concurrent observation and interview with Resident 1 on 1/28/2022, at 12:30 PM, Resident 1 was observed in bed, awake and alert. The head part of Resident 1's bed was elevated and a lunch tray was on top of over the bed table. Bilateral 1/4 side rails were up. No other fall precaution was observed. There were no signs of injury noted during skin observation.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056360	A. BUILDING _____ B. WING _____	C 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CARE CENTER	1033 E. ARROW HIGHWAY GLENDORA, CA 91740

(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 8 Resident had no roommate. Resident 1 stated, Certified Nurse Assistant 1 (CNA 1) was changing his linen when he fell. CNA 1 told him to roll on his side while she was tucking the linen under him. CNA 1 pushed him too hard and that's how he fell. CNA 1 ran outside to get help and came back with three other staff. Resident 1 stated, the side rails was not enough to help him because it was too small for him. Resident 1 stated, he did not consider it as physical abuse and it was not intentionally done to hurt him but nurse should have been careful. Resident 1 stated, he still has some pain on his shoulder and back and said that they took six views of X-ray yesterday. A review of Resident 1's, "Left Shoulder Radiology Results Report," dated 1/27/2022 at 18:34 (6:34 PM), and reported on 1/27/2022 at 19:56 (7:56 PM), indicated a "Normal left shoulder," with no changes indicating fracture or dislocation. A review of Resident 1's , "Spine and Thoracic (Chest) Radiology Report," dated 1/27/2022 at 18:34 (6:34 PM) and reported on 1/27/2022 at 19:56 (7:56 PM), indicated, "Minor degenerative changes (cushioning in the spine begins to wear away, most common in older adults)." A copy of the facility's policy and procedure for the use of side rails was requested on 3/11/2022 but was not provided.	F 700		