9/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 08/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITA	625 ASHLAND STREET ARCHDALE, NC 27263

(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 Amended on August 21,2015 initial comments added. On August 3, 4,5 and 7, 2015 a complaint investigation was conducted.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	1. The resident #1 no longer resides at the facility. 2. Resident in the facility have the potential to be affected an event that may cause injury. A resident with injuries of unknown origins will be reported to the Health Care Personnel Registry with the Department of Health and Human Services with 24 hour and 5 day of notification with identified injury. The Director of Nursing and the Executive Director will be involved with the investigation of injuries of unknown origins. Staff interviews will be conducted and incident report will be initiated. Resident diagnosis and mobility will be reviewed. The resident BIM's score will be evaluated and an interview will be conducted. Resident Care Plan will be reviewed to assess accuracy related to resident care needs.	09/04/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William K. Tennett — TITLE: Executive Director — (X6) DATE: 8/31/15

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 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to submit 24-hour and 5 day reports to the Health Care Personnel Registry for 1 of 5 sampled residents (Resident #1), who sustained injuries of unknown origin. Findings included: Record review for Resident #1 revealed the resident was admitted to the facility on 01/16/2015 with cumulative diagnoses of: Non - healing Pressure Ulcer of the Hip and Sacrum, Senile Dementia, Osteoporosis, Cognitive Communication Deficit, and Schizophrenia. Review of the annual Minimum Data Set (MDS) assessment dated 01/23/2015 and the quarterly MDS dated 04/16/2015 for Resident #1 indicated the resident required extensive assistance with two plus person physical assistance for bed mobility and transfers, had a Brief Interview for Mental Status Score (BIMS) of 6 (severe cognitive impairment), had signs of delirium such as disorganized thinking, and had no falls since admission. On 07/10/2015 Resident #1 had a fall to the floor. According to the SBAR Communication and Progress Note Form, the incident occurred at 1:45 AM. Review of the SBAR Communication Form dated 07/10/2015 read: Situation: Fall. Patient Evaluated. Primary diagnosis: Senile Dementia,	F 225	3. Education to all staff will be provided by the Director of nursing and Executive Director regarding reporting any event or accident at the time it occurred. An investigation shall take place within the facility to identify cause of injury. Each care giver will be interviewed to identify the source of injury. The Director of nursing will investigate all incident reports with and obtain information related to the event. The Executive Director or the Regional Director of Clinical Services will review the incidence and information to ensure that it is complete and care plans reflect changes. 4. The incident of injury of unknown origin will be discussed in the monthly Quality Assurance Meeting by the Executive Director and Director of Nursing for 3 months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance 5. 9/4/15	09/04/15

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F 225	Continued From page 2 Muscle weakness. Oximetry % 77% approved oxygen at 2 Liters per /minute via nasal cannula. Functional status changes: Fall. Respiratory symptoms: low pulse, oxygen applied at 2 Liters per minute via nasal cannula. LPN Nurse Assessment: " The resident is not her usual self. The left side of her mouth is drooping slightly. Fell on 11-7 shift at 1:45 AM. The resident went out to the hospital at 9:45 AM. Review of the facility investigation of 07/10/2015 read: Fall, location: resident's room, Activity: lying in bed. Witnesses: none. Bed lowered, Pain Evaluation, Placed in bed, Alert Charting, Initiated, Neuro Checks Initiated, Initiated 72-hour charting, Range of Motion Assessment, Medical Doctor notified. Nurse ' s note: Nursing Assistant found resident on the floor; reported to the nurse upon assessment resident was found on right side with no injuries. Unclear of how resident fell from bed to the floor; bed was in low position. Position when found: Found resident on right side on the floor. Care prior to the fall: Repositioned at 1:00 PM. Preventive measures at time of fall: Low bed. Root cause: Resident on a specialty mattress and resident ' s contractures and positioning; possibility that resident was not positioned correctly. Review of the ambulance report of 07/10/2015 read: Dispatch Reason: Stroke/CVA (Cerebrovascular Accident). Chief Complaint: Fall, Stroke, Altered Mental Status. Narrative: Dispatched emergency traffic referral stroke/cva. Arrived to (the resident) supine in bed secured by rails times two. Staff stated that patient fell out of bed at 1:00 AM, not acting right, was very lethargic, and not speaking. Staff also stated that the patient ' s right leg is usually rigid, was now flaccid. Patient on 2 liters of oxygen via nasal cannula. It is unknown if patient had hit her head.	F 225		

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F 225	Continued From page 3	F 225		

No neurological deficits found.
Review of the hospital report completed 07/17/2015 indicated Resident #1 was admitted with diagnoses of Bilateral femur fractures, Sepsis secondary to urinary tract infection and pneumonia, and advanced dementia. The hospital RN triage read: Fall-approximately 3 feet from bed, landing on tile floor. Found on floor by night staff at nursing home. Injury occurred at time unknown and injury location: nursing home. Day staff states patient is not acting normal. Normally speaks very loudly. Today unable to speak. Has contractures both lower legs normally. Today right leg is straight. The report further indicated, the radiology studies for the right knee was completed on 07/13/2015. The report read: Findings: Moderately displaced and possibly comminuted fracture is seen involving the distal right femur. Hospital Course and Treatment: Here in the ED (Emergency department) x-rays revealed bilateral femur fractures.
A staff interview with the Director of Nurses (DON) conducted on 08/05/2015 at 3:20 PM indicated, "The facility did not find out about the fractures until 07/17/2015 from the family when they came into the facility. "
Record review revealed no documentation that 24 -hour or 5 day reports had not been completed and submitted to the Health Care Personnel Registry regarding the fall with injury for Resident #1.
An additional staff interview with the DON on 08/07/2015 at 2:39 PM. The DON indicated, " It is still unclear to us as to how the resident ended up with the fall, due to bed mobility. The educational guess was that the resident had the ability to cause slight movement, which could cause misalignment, bringing her out of the

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F 225	Continued From page 4 center of the bed which could have caused her to slide to the floor. "	F 225		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with staff, the facility failed to position Resident #1 in a manner to prevent a fall from the bed to the floor. As a result, the resident sustained bilateral femur fractures. The facility also failed to position Resident #1 in a manner to prevent leaning over against metal side rails. As a result, Resident #1 sustained a bruise to the left lower jaw, and a swollen left upper lip. This was evident for 1 of 5 residents (Resident #1) in the sample reviewed. Findings included: A. Record review for Resident #1 revealed the resident was admitted to the facility on 01/16/2015 with cumulative diagnoses of: Non - healing Pressure Ulcer of the Hip and Sacrum, Senile Dementia, Osteoporosis, Cognitive Communication Deficit, and Schizophrenia. Review of the annual Minimum Data Set (MDS) assessment dated 01/23/2015 and the quarterly MDS dated 04/16/2015 for Resident #1 indicated the resident required extensive assistance with	F 323	1. Resident # 1 no longer resides in the facility. 2. Residents that currently reside in the facility have the potential to be affected have had an audited completed by the Maintenance Manager and the Director of Nursing for bed functioning and that they are mechanically sound. Resident that require specialty mattress will be review for appropriateness of the required mattress and that the resident has been reviewed for self-care needs and bed mobility. Resident positioning and alignment while in bed and using a specialty mattress will be care planned. 3. The Director of Nursing, Executive Director, Unit Manager, Maintenance Manager, and Environmental Service Director will complete re-education regarding	09/04/15

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F 323	Continued From page 5 two plus person physical assistance for bed mobility and transfers, had a Brief Interview for Mental Status Score (BIMS) of 6 (severe cognitive impairment), had signs of delirium such as disorganized thinking, and had no falls since admission. The Care Plans of 01/28/2015 and 04/17/2015 read: Focus Category: Safety and Focus: Potential for falls read: Follow facility fall protocol. There were no interventions for positioning of the resident. Under the Focus Category: Skin/wound, the intervention read: Assist resident with turning and positioning, and the resident will be turned/repositioned. There was no time frame for turning/repositioning and no turning type (right/left only or back/left only) specified, and no indication as to number of staff necessary to position/reposition the resident. On 07/10/2015 Resident #1 had a fall to the floor. According to the SBAR Communication and Progress Note Form, the incident occurred at 1:45 AM. Review of the SBAR Communication Form dated 07/10/2015 read: Situation: Fall. Patient Evaluated. Primary diagnosis: Senile Dementia, Muscle weakness. Vital signs: B/P 98/54, Pulse 124, Apical HR 124, Respiratory Rate 16, Temperature 97.8 . Oximetry % 77% approved oxygen at 2 Liters per /minute via nasal cannula. Functional status changes: Fall. Respiratory symptoms: low pulse, oxygen applied at 2 Liters per minute via nasal cannula. LPN Nurse Assessment: " The resident is not her usual self. The left side of her mouth is drooping slightly. Fell on 11-7 shift at 1:45 AM. Request: Monitor vital signs. Transfer to the hospital. Nursing notes: Resident was not acting like her usual self. Her left side of her mouth was drooping slightly. The resident responded to her name when writer	F 323	equipment and reporting of malfunctioning equipment. Audits will be conducted 3 times a week for 3 months by the Director of Nursing, Unit manager, Executive Director, and the Environmental Director. Re-education will be conducted on reporting equipment failure including the removal and notification to the Maintenance Manager of equipment taken out of service. Equipment will be stored and tagged so that it will not be introduced back into the facility as working equipment. Residents that reside in the facility that have a potential to be affected relate to specialty mattress will be reviewed for the mattress to fit securely to the bed and fits appropriately to the frame, the residents care plan will be reviewed to ensure that they have been identified for the need to use specialty mattress and the proper alignment	09/04/15

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F 323	Continued From page 6 spoke to her, but in a whisper. Pulse oxygen at 77%, applied oxygen at 2 liters per minute via nasal cannula. Checked pulse Oxygen 10 minutes later at 93%, called Medical Doctor, ambulance, and Responsible Party. The resident went out to the hospital at 9:45 AM. " Review of the facility investigation of 07/10/2015 read: Fall, location: resident's room, Activity: lying in bed. Witnesses: none. Temperature 96.7, blood pressure 120/70, Respiration 20, Apical Pulse 88, and O2 sat 96. Immediate Action Taken: Family called , Call light within reach w/instruction, Bed lowered, Pain Evaluation, Placed in bed, Alert Charting, Initiated, Neuro Checks Initiated, Initiated 72- hour charting, Range of Motion Assessment, Medical Doctor notified. Nurse ' s note: Nursing Assistant found resident on the floor; reported to the nurse upon assessment resident was found on right side with no injuries. Unclear of how resident fell from bed to the floor; bed was in low position. Position when found: Found resident on right side on the floor. Care prior to the fall: Repositioned at 1:00 PM. Preventive measures at time of fall: Low bed. Root cause: Resident on a specialty mattress and resident ' s contractures and positioning; possibility that resident was not positioned correctly. Investigation initiated. State of motion at time of fall: lying in bed. Change in medications prior: Zyprexa 7.5 milligrams. Current 5 milligrams changed one week prior to the fall. Recommendations: Resident neuro checks started and the nurse aide 1:1 (NA#2) initiated. Review of the statement from NA # 2 for the fall of 07/10/2015 read, "I was working with (Resident #1) on 11-7 (shift). I provided incontinent care approximately 1:05 AM. I placed her on her left side facing the window. I placed pillows under her legs, and between the legs and the mattress. I	F 323	relate to the use of the specialty mattress. The Director of Nursing, Unit Manager, and Weekend Supervisor will in-service the staff on the proper use specialty mattresses related to resident needs, mattress function, proper body alignment, and functioning of mattress. The Director of Nursing, Unit Manager, and the weekend supervisor will audit the residents that use specialty mattress 3 times weekly for 3 months. 4. The findings that were noted through the conducted audits will be reviewed in the August Quality Assurance meeting. The committee will review and recommend revisions to sustain substantial compliance. 5. 8/31/15	09/04/15

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placed a pillow behind her upper back. She was off the wound on the left hip. I left the room and went to provide care for the ladies in room 131. I continued to work on my rounds, took out my trash then proceeded to F hall. At approximately 1:35 AM I walked by the nurses station and the nurse asked me what was that noise. I walked down the hall and saw (Resident #1) on the floor on her right side. "

Review of the ambulance report of 07/10/2015 read: Dispatch Reason: Stroke/CVA (Cerebrovascular Accident). Chief Complaint: Fall, Stroke, Altered Mental Status. Narrative: Dispatched emergency traffic referral stroke/cva. Arrived to (the resident) supine in bed secured by rails times two. Staff stated that patient fell out of bed at 1:00 AM, not acting right, was very lethargic, and not speaking. Staff also stated that the patient ' s right leg is usually rigid, was now flaccid. Patient on 2 liters of oxygen via nasal cannula. It is unknown if patient had hit her head. No neurological deficits found.

Continued review of the MDS assessments revealed there was a change on the current quarterly MDS assessment dated 07/10/2010 (after the fall). The 07/10/2015 MDS assessment indicated Resident #1 was totally dependent on staff for bed mobility and transfers, and had one fall since admission, with no injury.

The Care Plan updated on 07/17/2015 (after the fall) read: Focus Category: Safety. Focus: Potential for falls. The resident has potential for injury. Etiologies: Poor safety awareness, confusion at times, and psychotropic drug use. New Interventions: Monitor for adverse side effects of psychotropic medication use, medication review monthly, keep bed at low position, use green mark on wall as indicator for bed height, mechanical lift to personal

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F 323	Continued From page 8 wheelchair, 1:1 supervision as needed, assess resident for use of side rails or transfer device. Review of the hospital report completed 07/17/2015 indicated Resident #1 was admitted with diagnoses of Bilateral femur fractures, Sepsis secondary to urinary tract infection and pneumonia, and advanced dementia. The hospital RN triage read: Fall-approximately 3 feet from bed, landing on tile floor. Found on floor by night staff at nursing home. Injury occurred at time unknown and injury location: nursing home. Day staff states patient is not acting normal. Normally speaks very loudly. Today unable to speak. Has contractures both lower legs normally. Today right leg is straight. The report further indicated, the radiology studies for the right knee was completed on 07/13/2015. The report read: Findings: Moderately displaced and possibly comminuted fracture is seen involving the distal right femur. Hospital Course and Treatment: Here in the ED (Emergency department) x-rays revealed bilateral femur fractures. Orthopedic surgeon advised conservative treatment with brace. The patient was found to have left upper lobe pneumonia with persistent hypoxia. Respiratory status never really improved. Palliative care conference with the family. The family decided to make the patient comfort measures and transfer to a Hospice home. A staff interview was conducted on 08/03/2015 at 3:52 PM with the first shift charge nurse (Nurse #3). Nurse #3 indicated, "When I went to check on her, her oxygen level had dropped, and the left side at the corner of her mouth was drooping a little bit, and she was not talking like she usually did, she was talking in a whisper, and not acting like her usual self. I called the doctor and another nurse stayed in the room with her while waiting	F 323		

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for the ambulance to come and while I was getting the paper work done and while I was calling the family. It was about 7:30 AM after we got report, when the third shift Nurse (Nurse #4) reported the fall to me. Nurse #4 reported to me that the resident had fallen out of bed. (Nurse #4) did not know how the resident had fallen out of bed. The third shift was doing neuro checks and everything was okay. The third shift nurse (Nurse #4) said the next neuro check would be at 8:30 AM. I went in to her room around 7:45 AM, and I went down the hall to check on all my residents, and discovered the low oxygen level. Her oxygen level was around 76 and I was more concerned about the oxygen and her breathing than anything else, and I called the doctor. I thought it could possibly be a stroke, but I am not a doctor, and that is why I called the doctor and sent her out."
A possible interview with the attending physician was not feasible during the investigation due to the attending physician being out of the country.
A staff interview conducted on 08/04/2015 at 11:50 AM with third shift nurse (Nurse #5) regarding the circumstances of 07/10/2015 when Resident #1 fell out of bed. Nurse #5 stated, " I do know that (Resident #1) was on the floor when I saw her, and I assessed and palpated from the neck all the way down to her feet to make sure there were no deformities. Her legs were normally contracted, and I did not feel any abnormalities when I palpated. We did get her off the floor, and we used three people to do that, and lifted her back onto the bed. She was talking a lot that night, and she kept repeating something about, "helping her momma in the bathroom." (Nurse #4) did call the doctor. "
A direct care staff interview was conducted on 08/04/2015 at 4:20 PM with NA #2, who found the resident on the floor on 7/10/14. The NA stated, "I

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F 323	Continued From page 10 did my first round at 11:00 PM and she was fine. At 1:00 AM, I started my second round. I was working two halls that night. I finished rounds on E Hall and then went to F Hall. When I came off F Hall, and I got by the nurses station and we heard a noise like a cat purring. I had completed care on her at 1:05 AM and had positioned her on her left side, and put one pillow under her knees and one under her legs, also a pillow behind her back. I ' m not sure if I put her in the middle of the bed or not. I attempted to place her in the center of the bed, but might not have been perfectly in the center " . When asked if NA#2 had left the rails up, NA #2 indicated, " I never put the rails down, because she was in a newer bed. She had plastic rails that stopped closer to the head board. It wasn ' t a full bed rail. " When asked why she did not have help to position the resident, NA #2 indicated, " We had 3 NA ' S working, but they were busy, so I thought I could do it myself. I went to the nurse ' s station, then I went to the room and saw she had fallen on the floor on her right side. The bed was in low position. There was a green marker in her room, and I always put the bed below that green tape. I did not notice anything abnormal about the bed or mattress, and that is why I was so shocked that she was able to fall out of the bed. None of us saw her fall. I hollered up to the desk because I never leave my patients when they fall, and both of the Nurses (Nurse #4 & Nurse #5) came down to do an assessment on her." An observation of the bed and measurement of the distance from the mattress to the floor was conducted on 08/05/2015 at 12:00 Noon, in the presence of the DON. The distance from the mattress to the floor was measured at 20 inches. This would have been the distance Resident #1 had fallen.	F 323		

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A staff interview conducted on 08/05/2015 at 12:35 PM with the third shift nurse (Nurse #4) regarding the circumstances of 07/10/2015 when Resident #1 fell out of bed. Nurse #4 indicated, "I was the nurse that was taking care of her. About 11:45 PM at night I did a walk through and she was in her bed. Around 1:00 - 1:35 AM, I was at the desk, and we heard a noise, like a moan or something. I told the Nursing Assistant (NA #8) to go check and see what was going on. She checked all the rooms, and when she got to (Resident #1 ' s) room, she saw her on the floor, and stayed with the resident and hollered for me to come and check her. We could not understand how she fell out of the bed, because she was the only person on the hall who did not move. She was positioned in the bed on her right side with a pillow wedged behind her back and pillows between her legs where the pressure points are, and under her feet, so she was completely off the hip and sacrum where the pressure ulcers were. When I entered the room, (Resident #1) was on the floor with her head at the bottom of the bed and her feet at the top of the bed. Her shoulders were on the right side facing the bed. That was like a total flip, and we didn't hear anything that night to suggest she fell out of bed. I was baffled as to how she fell. We assessed her from head to toe, joints and all. Her legs were still contracted. Also (Nurse #5) assessed her. When I assessed her, and asked her what she was trying to do, she said she was trying to go help her mother. Further assessment revealed she did not complain of pain, she had no bruises, no swelling, no redness to indicate she had been on the floor a while. The mattress was level and the bed frame was level. She was a small lady, and we positioned her very well with pillows because of her pressure ulcers. We had an in-service about the mattress right

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after the incident with (Resident #1). I think the mattress was the reason she fell out of the bed, and because she doesn't really move. The mattress is the only logical reason, because it can push a patient forward when they move. I started neuro checks on her every 15 minutes for the first hour, and then every hour for four hours, and then I started 15 minute safety checks on her too, and she had someone in her room practically all night to make sure she was safe. We did a three person transfer to move her from the floor back to the bed, and she did not complain about pain. After we got her in the bed, her legs were still contracted at the knees, and she did not complain of any pain, her vital signs were normal and no changes. On my shift, she was still responding. She stayed on third shift until day shift, then was sent out to the hospital on day shift."

A staff interview with the Director of Nurses (DON) conducted on 08/05/2015 at 3:20 PM indicated, "The facility did not find out about the fractures until 07/17/2015 from the family when they came into the facility, and that is when I was informed that the resident was going to the Hospice House. I did in-services on 07/24/2015 with all the staff about our specialty air mattresses. It was a train the trainer type in-service from the mattress company representative.

An additional staff interview with the DON on 08/07/2015 at 2:39 PM regarding her expectations related to positioning of the resident, "That the resident would be positioned appropriately in the center of the bed. Also to make certain if there were any support devices that they would be properly positioned for resident safety. " It is still unclear to us as to how the resident ended up with the fall, due to bed

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mobility. The educational guess was that the resident had the ability to cause slight movement, which could cause misalignment, bringing her out of the center of the bed which could have caused her to slide to the floor. "
B. Record review for Resident #1 revealed the resident was admitted to the facility on 01/16/2015 with cumulative diagnoses of: Non - healing Pressure Ulcer of the Hip and Sacrum, Senile Dementia, Osteoporosis, Cognitive Communication Deficit, and Schizophrenia.
Review of the Admission Care Plan of 01/16/2015 read: bed mobility with ¼ side rail.
Review of the Admission/Readmission Data Collection Form completed on the date of admission of 01/16/2015 read: Side Rail Evaluation: Resident non-ambulatory, demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed, difficulty with balance or trunk control. The resident requested the side rails not be released while sleeping. Interventions: Lower bed to the floor, visual and verbal reminders to use the call bell. Recommendations: At this time, side rails are indicated to provide safety. Side rails are indicated and serve as an enabler to promote independence.
The Care Plan initiated 05/16/2015 read: Focus: Skin/Wound. Interventions included: May use 1/4 side rails as an enabler for mobility.
Record review indicated Resident #1 had an unobserved incident on 06/23/2015 when the resident ' s bed frame was broken and leaned to the right side. The metal bed rails were also loose. The resident was found with her head and neck against the rail and mattress, and her face lying on the rail. The resident sustained a bruise on the left lower jaw and received a swollen left upper lip.

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F 323	Continued From page 14 Review of the SBAR (Situation Background Assessment Request) Communication Form of 06/23/2015 read: "Bruise to left lower jaw. Assessment No distress, small bruised area to (L) lower jaw. Able to move neck without complaint of pain or discomfort. No complaint to jaw. Nursing notes: 6/23/2015 at 12:20 PM, NA (Nursing Assistant) in to feed resident lunch. Resident's bed uneven and leaning to the right side. Resident on low air loss with alternate pressure specialty mattress. Resident positioned with 2 pillows on the right side. Resident's head/neck against bed rail and mattress. Small bruise - quarter size noted on left lower jaw. Left side of face lying on rail. Unable to move herself off rail/mattress. Three staff members positioned resident in bed. Positive range of motion to neck. No complaint of pain to lower left jaw or neck upon movement. Doctor made aware. New orders to x-ray cervical and thoracic spine and left mandible. At 4:00 PM resident's left upper lip with slight swelling. Denies pain. " Review of the Physician's orders for 06/23/2015 read: X-ray cervical spine and thoracic spine x-ray (left) mandible due to injury/pain. Review of the Radiology Reports of 06/23/2015 read: Mandible 1-3 Views, Left. Results: No displaced acute fracture is seen. C-Spine/Neck. Results: There is mild kyphoscoliosis. There is multilevel disc disease present. No displaced acute vertebral fracture. Review of the Action Plan for Potential for Accident/Injury read: Date Identified: 6/23/2015 read: Root Cause/Causes: 1. Mattress and bed rails are in proper working order. 2. Assist rails are needed or are requested by the resident to act as enabler to allow residents to participate with care and define parameters. 3. Evaluate. Actions to be taken 1. Audit all resident ' s bed	F 323		

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and side rails for proper fit and good repair. Target date 6/23/2015 Outcome: (Resident #1) had her bed frame changed related to right side tilt with bed frame 6/23/2015. Mattress fit properly to bed frame but bed frame tilted to the side. 2. Identify all residents using air mattresses. Target date 6/23/2015. Outcome: (Resident #1) -stage-4 wound Right hip and sacrum. 3. Evaluate appropriateness of side rails. Has Quarter Rails to act as enabler. Resident will hold to side rail when care is rendered. 4. Complete side rail assessment need and safety review for all residents. All residents have Side Rail Evaluations completed for use and appropriateness. 5. Kardex to indicate use of appropriate.

Review of the Facility Investigation and Action Plan entitled Bruise Root Cause Investigation Report completed 06/23/2015 read: Location: Resident room, Appearance: Red, Purple bruise. Cognitive status: Alert, with periods of confusion. External Contributing Factors: Transfer status: Hoyer, Bed Mobility Status: Dependent, Bed Mobility: Side Rails. Unusual circumstances past 24 hours contributing to cause of the bruise: uneven bed. Leaning to the right side. Other contributing equipment: Side rails loose. What activity was resident engaged prior to the bruise? Eating and during meal tray distribution. Staff interviews past 24-48 hours for cause-or contributing factors completed: Side rail 1/4 length and bed broken-leaning to the right side. Summary: Bed leaning R side. Resident face/neck against side rails and mattress. Side rail against left face. New bed given to resident.

Interview with the Director of Nurses (DON) on 08/03/2015 at 12:46 PM indicated, " On 06/23/2015 (Nurse #1) reported the resident's bed was tilted to the right. It was the frame, and

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the resident was found leaning to the right side of the bed. The side rail was loose. (Resident #1 ' s) face was against the rail, and the DON was concerned about the resident receiving bruising to her face. We ordered x-rays, changed the bed frame, rails and all. The resident was provided a completely different bed. The resident was assessed and had sustained a quarter size bruise, and the bruise was monitored. Neuro checks were done. The x-rays were done in the facility. On 06/23/2015 every bed in the facility (a total of 62 beds) was audited for: mattress affixed, mechanically sound rails, rails firmly attached, mattress condition, bed frame condition, bed rail condition, and no other resident bed concerns as a result of the audit. The bed was removed and the resident was given another bed." There were no other corrective measures.
A staff Interview conducted on 08/03/2015 at 2:43 PM with the Nurse #1 who investigated the bruise indicated the Nursing Assistant (NA #1) reported the resident was found leaning to the right side, and the left side of her face was against the bed rail. This occurred when the NA #1 went into the room to feed the resident at lunch time. When I went into the room, I saw the right side of the bed frame at the head of the bed was uneven and leaned to the right side. The resident was positioned on the right side with 2 pillows behind her back. When I went into the room, we immediately pulled her away from the bed rail, and repositioned her to the center of the bed. I did an assessment. She received a bruise to her left lower jaw and her left upper lip was swollen. She was not yelling out; had not yelled out. She was not complaining of pain, moving her neck on her own. After I did my assessment, I called the doctor, I received new orders for x-ray cervical and thoracic spine and left mandible, I notified the

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family. The NA ' S got her in the wheelchair for lunch and stayed with her and fed her. While she was up out of the bed, the bed was changed out to a different bed the day of the incident. The x-rays done on 06/23/15 were negative.
Attempts to contact NA # 1 on 08/03/2015 at 3:00 PM, and on 08/04/2015 at 12:30 PM were unsuccessful.
A staff Interview with the Maintenance Director conducted on 08/04/2015 at 4:45 PM indicated he had a preventative maintenance system on line for bed functionality and safety. When asked to show documentation the beds and bed rails were checked in June and July, the staff member indicated prior to the incident of 6/23/2015, " We just went off of the online Preventive Maintenance Reporting System which included a monthly check of connectors on rails, and tighten as necessary. Check for gaps in the area between the mattress and the rail. Remove any burs or rough edges to prevent injury. Also inspect cranks if applicable. Check for missing or faulty screws. The check was done on 06/19/2015. "
This check did not include checking the frame of the bed .The Maintenance Director was unable to verify that the bed occupied by Resident #1 had been checked prior to the incident. The Maintenance Director indicated that on the date of the incident (1st shift at lunch time on (6/23/2015), "When I came in, the bed was out in the hallway. I removed the bed out of the facility because when they told me it was defective, I got rid of it because it was a safety hazard. I did not check it, I just removed it from the facility and the Scrap Removal Company who we have a contract with came and took it to a scrap yard. "
Review of the maintenance logs for June 2015 indicated there were no concerns documented for the resident's rails and no concerns with the

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F 323	Continued From page 18 mattress or bed frame until 6/23/2015. An additional interview with Nurse #1 conducted on 08/05/2015 at 10:15 AM regarding the incident of 6/23/15 revealed, "The head of the bed was broken, and the side rails were looser than normal. Standing at the foot of the bed, the side rail 1/4 length and the bed was broken. The bed was leaning to the right side. It was an electric bed. That bed was removed on 6/23/2015, and moved to C Hall, and the Maintenance Director moved it outside. An electric bed was put in the room as a replacement. At 11:00 AM on 08/05/2015 Nurse #1 and Nurse #2 demonstrated Resident #1 ' s position in the bed when found with her face against the bed rail on 06/23/2015. The staff demonstrated the bed was in the lowest position. The head of the bed was up. Per Nurse #1, the resident had been positioned in the bed on her right side with pillows between her legs and memory foam pillows were behind the resident's back. Nurse #1 explained and demonstrated that at the time of the incident the top of the head area of the bed was found leaning to the left. The resident had rolled onto the left side on her face. Her feet and legs were on the bed, but at the edge. The resident's chin was hitting the metal bars; the face was not through the rail; the chin was against the railing. Her lip did swell up. The metal bars were the vertical kind. She was not between the mattress and the rail. Interview with the DON on 08/05/2015 at 12 Noon indicated the DON had no knowledge of why the bed had broken. She stated, "Beds will just break, just like your car does." Direct Care staff interviews were conducted on 08/05/2015 from 12:00 noon to 12:45 PM on with NA #3, NA #4, NA #5, and NA #7 who were on the schedule for 06/23/2015. When asked about the	F 323		

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type of bed the resident was in at the time of the incident, the condition of the bed, and which NA changed the bed out of the room and replaced with another bed, the staff interviewed did not know. NA #6 was unavailable for interview.
A staff interview with the Physician's Assistant (PA) was conducted on 08/05/2015 at 2:45 PM. The PA indicated she saw the resident on 06/24/2015 and "There were no concerns of pain and no problems with the resident the day I was there. I reviewed the x-rays from the incident with the bed rail, and the x-rays were negative for fractures. The facility had changed the bed out."
A direct care staff interview was conducted on 08/06/2015 at 10:00 AM (via a returned telephone call) with NA #1 who indicated being the first staff member who found the resident ' s left side of the face on the rail on 06/23/2015. NA #1 identified the rails (quarter metal, vertical rails) used on the bed when the resident was found on 06/23/2015. NA #1 indicated, " When I went in the room to feed the resident around 12:30 PM, when facing the bed, I saw her on her left side with her face pressed against the rail. I got (Nurse #1) to help position her centered in the bed with pillows around her. "
A staff interview conducted on 08/07/2015 at 10:30 AM with Nurse # 6 indicated the nurse was the staff member who moved the broken bed out of the room on 06/23/2015. Nurse #6 indicated, " I changed the bed out of the room. Between 12:30 PM - 2:00 PM. I found another electric bed. I checked the bed before I put it in there. The frame was fine. The bed I put in there was the bed she had when she left on 07/10/2015. Anytime I change a bed I check it to make sure it was operating okay. There was no shortage at the plug of the other bed. The frame was slightly bent of the one I took out of the room. I took it

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F 323	Continued From page 20 down at the C Hall, which is where we take beds that are out of service, so the Maintenance Director can discard them. " A possible interview with the attending physician was not feasible due to the attending physician being out of the country.	F 323		