STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	**120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328**

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 9/4/15. Event ID # LTXF11. Complaint intake # NC00103794. On 8/30/15 through 9/4/15 a recertification and complaint investigation survey was conducted. On 9/2/15 an extended survey was conducted. 483.13 at a scope and severity (J) F-221 Immediate jeopardy (IJ) began on 8/21/15 for Resident #160 and began on 8/31/15 for (Resident #78). The facility failed to have a medical symptom for the continued use of side rails for two residents with side rails used as restraints by allowing the use of the side rails for a resident that was observed attempting to get out of bed resulting in a fall with her arm stuck in the side rail. Also by failing to implement the side rail padding to prevent it from happening again for Example #1 (Resident #160). There was another resident observed attempting to get over the side rail with one leg through and one leg over the side rail and a second observation of the same resident with one leg wedged between the high-low mattress and side rail for Example #2 (Resident #78). 483.25 at a scope and severity (J) F-323 Immediate jeopardy (IJ) began on 8/21/15 for example #1(Resident #160). Immediate jeopardy began on 8/31/15 for example #2 (Resident #78).	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2015

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F 000	Continued From page 1 The facility failed to assess residents for hazardous side rails for a resident that was observed by a family member attempting to get out of bed resulting in a fall with her arm stuck in the side rail. Also by failing to implement the side rail padding to prevent it from happening again (Resident #160). For another resident observed attempting to get over the side rail with one leg through and one leg over the side rail. Also with a second observation of the same resident with one leg wedged between the high-low mattress and side rail (Resident #78). The Administrator was notified of the Immediate Jeopardy on 9/2/15 at 3:06 PM. The Immediate Jeopardy was removed on 9/4/15 at 3:30 PM when the facility implemented a credible allegation of compliance. The facility remained out of compliance at the lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an	F 157		10/2/15

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F 157	Continued From page 2 existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interviews, the facility failed to notify the physician and the responsible party (RP) of a newly assessed bruise for one of one resident (Resident #160) with a bruise. Findings included: Resident #160 was admitted to the facility on 5/8/15 with diagnoses of hypertension, non-Alzheimer ' s Dementia with behaviors disturbances and with a history of falls. A review of the most recent quarterly Minimum Data Set (MDS) dated 8/15/15 and her admission MDS dated 5/15/15 revealed Resident #160 had short and long term memory problems. A review of skin checks dated 8/23/15 revealed there were no new skin area concerns. A review	F 157	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility¿s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F157 Corrective Action for Affected Residents For resident # 160 the physician was faxed by the charge nurse regarding the	

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F 157	Continued From page 3 of skin checks dated 8/29/15 revealed there were no new skin area concerns. During an interview on 9/03/15 at 2:04 PM Resident #160 ' s responsible party stated that the facility had notified her about 2 weeks ago concerning the resident getting her left arm caught in the side rail. She was then observed lifting up the sleeves to Resident #160 ' s left upper arm and her right upper arm. Resident #160 ' s left arm was observed without a bruise. Resident #160 ' s right upper arm was observed with a dark purple bruise approximately 2 inches long and 1 inch wide. The responsible party stated the facility had not notified her about her right arm and her arm looked like the side rail had bruised her. The responsible party asked Resident #160 how she got the bruise and she stated she got her arm caught in the side rail. During an interview on 9/3/15 2:06 PM Nurse #7 stated she was not aware of her having a bruise and stated she would call the physician. Nurse #7 was observed asking Resident #160 how she had gotten the bruise and Resident #160 stated she got her arm caught in the side rail. On 9/3/15 2:23 PM with Nurse #7 and NA #12 present, NA #12 stated she had been assigned to Resident #160 on 9/2/15 and she had not seen the bruise. NA #12 stated that had also been assigned to be Resident #160 ' s NA on 9/3/15 and saw the bruise while she was bathing her at 7:30 AM. NA #12 further stated she had not thought about it until Nurse#7 questioned her about the bruise and she had just reported it. NA #12 stated she asked the resident how she thought it happened and Resident #160 told her she hurt it in the side rail. Nurse #7 stated the area looked like an older bruise that happened several days ago. She stated it did look like the bruise was from the side rail on her upper arm.	F 157	bruise to the right arm on 9/3/15 immediately after assessing the bruise. The physician responded at 3:15 PM with an order to monitor the bruise. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 9/3/15 the nurses assessed all current residents for abnormal skin conditions. This includes bruises, skin tears, pressure ulcers, and rashes. If any of these areas were identified the patients chart was reviewed to ensure that the physician had been notified. If notifications had not occurred the nurse contacted the physician and responsible party. This was completed on 09/03/15. Systematic Changes On 9/3 and 9/4/15 the nurse managers began in-servicing all current nursing staff (NA, RN, LPN, both full time and part time regarding the notification of skin conditions to the charge nurse and physician. This in-service included the following topics: Nursing assistants who identify any new skin condition such as a bruise, skin tear, pressure ulcer or rash must inform the charge nurse of the condition. The nurse must then contact the physician according to Interact 4 guidelines for reporting contusions. Contusions accompanied by significant pain or bleeding must immediately be reported to the physician. Contusions associated with a recent fall with no other complications should be reported to the	

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F 157	Continued From page 4 During an interview on 9/4/15 at 11:56 AM the Director of Nursing (DON) stated that she had been a part of the clinical meeting concerning Resident #160 ' s 8/21/15 fall. The DON stated she met with the Administrator, the Unit Manager and the MDS Coordinator. The DON stated her expectation for staff would be to notify the physician immediately when they found the bruise.	F 157	physician using their preferred contact method (paging/faxing) to notify them of the skin condition. Physician contact information is located at the nurse¿s station and all nurses have been educated as to where this information is located. On 09/24/15, a Nursing in-service was held and all Nurses present were notified of the following requirement for responsible party notification. The nurse must also notify the resident¿s responsible party of the bruise and document notification in the incident report or progress notes. The Director of Nursing will ensure that any nurse who has not received this training by 10/02/15 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all nurses and CNA¿s and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Bruises¿. The monitoring will include reviewing 5 skin assessments for newly identified bruises and incident reports. From this review up to 10 patients will be reviewed for physician and responsible party notification. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated	

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F 157	Continued From page 5	F 157	as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 221 SS=J	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and family interviews, the facility failed to have a medical symptom for the continued use of side rails for two residents with side rails used as restraints by allowing the use of the side rails for a resident that was observed attempting to get out of bed resulting in a fall with her arm stuck in the side rail and by failing to implement the side rail padding to prevent it from happening again for Example #1 (Resident #160) and a resident observed attempting to get over the side rail with one leg through and one leg over the side rail and a second observation of the same resident with one leg wedged between the high-low mattress and side rail for Example #2 (Resident #78). The facility also failed to have a medical symptom for the continued use of a Geri chair for a resident placed in a Geri-chair that prevented her from rising as a restraint after she was assessed by therapy as requiring supervision while in the	F 221	Credible Allegation for Tag 221 Corrective Action for Affected Residents Resident # 78: resident was sent to hospital on 11/04/2014 for evaluation of left hip and femur swelling. Resident returned to facility with status post ORIF (Open Reduction Internal Fixation). At that time resident was continued with fall precautions of hi low mattress, chair alarm, personal alarm, bed alarm, floor mat, and floor mat alarm. Resident continues to use a geri-chair when getting up and is positioned at the nurse¿s station for monitoring by staff. The patient will be re-evaluated by therapy to see if alternative seating arrangements can be made. Therapy screened the patient on 9/3/15 and decided to pick the patient up for possible broda chair utilization. Additionally on 9/3/15 the care	10/2/15

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F 221	Continued From page 6 Geri-chair for one of one resident for Example #3 (Resident #78) that received a femur fracture after falling from the Geri-chair. Immediate jeopardy (IJ) began on 8/21/15 at 11:10 AM for example #1(Resident #160). Immediate jeopardy began on 8/31/15 at 2:30 PM for example #2 (Resident #78). Immediate jeopardy was removed on 9/4/15 at 11:39 AM when the facility provided a credible allegation of compliance. Example #3 (Resident #78) was cited at a G (isolated deficiency that constitutes actual harm that is not immediate jeopardy). The facility will remain out of compliance at a scope and severity of level D (isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy). The facility was in the process of full implementation and monitoring their corrective action. Findings included: 1. Resident #160 was admitted to the facility on 5/8/15 with diagnoses of hypertension, non-Alzheimer ' s Dementia with behaviors disturbances and with a history of falls. A review of the most recent quarterly Minimum Data Set (MDS) dated 8/15/15 and her admission MDS dated 5/15/15 revealed Resident #160 had short and long term memory problems. Resident #160 was coded as having verbal behavioral symptoms directed toward others and rejected care. She required extensive care for transfer and bed mobility with one person assist. She was not steady moving from a seated to standing position and moving form surface-to-surface transfer. She had impairment on both sides of her lower extremities. Bed rails, trunk restraint,	F 221	plan team evaluated the use of the hi low mattress. The team decided to continue the use of the hi low mattress and reevaluate weekly for a maximum of 30 days since the side rail reduction has also occurred. The care plan team also completed a device evaluation related to the side rail and discontinued its use on 9/3/15 as a result of the evaluation. Resident # 160: was admitted to the facility on 05/08/15. Resident fell on 05/08/15, a urine analysis was ordered and personal alarm and floor alarm was in place. Resident experienced a fall on 05/10/15 and bed alarm was added and therapy was initiated on 05/12/15. On 06/14/15 the resident fell and was placed at the nurses station with staff for close monitoring. On 07/25/15 the resident fell and a therapy screen was initiated. On 08/21/15 the resident fell and side rail pads were ordered and non-skid socks were put in place. On 9/3/15 the bedrails were removed from the bed as a result of the side rail assessment completed on 9/3/15 by the care plan team. 9/3/15 a bruise was located on the right arm where the staff, family, resident interviews stated that it came from the side rail. The physician was notified on 9/3/15 at 1:58 PM. He responded at 3:15 to monitor the bruise Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 9/2-3/15 the nurse managers completed device evaluation forms on all current residents. This was accomplished	

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F 221	Continued From page 7 limb restraint or chair that prevented rising were coded as not being used. A review of Resident #160 ' s Care Area Assessment (CAA) dated 5/21/15 revealed she triggered for behaviors and falls. Resident #160 had short and long term memory problems and a few episodes of refusing medications over the last week and yelling at a nurse (The assessment date was 5/15/15.) She was admitted to the facility after a fall from home for rehabilitation, strengthening and endurance. The facility proceeded to care plan due to behavioral symptoms and a history of falls. Resident #160's last side rail assessment was completed on 5/8/15. Resident #160 was unable to state preference about her side rails. She was assessed to have ½ length side rail on both sides. She was assessed as having a history of falls and was mobile while in bed. She did have enough mobility to turn from side to side but had not attempted to get out of bed. She was assessed as having a decreased safety awareness due to confusion or judgment problems. Staff decision was for her to continue current side rail usage. A review of her care plan dated 5/11/15 revealed Resident #160 was at risk for falls related to her being unaware of safety needs. She had poor communication and comprehension with gait and balance problems. All interventions were started on 5/11/15 and there were no updates concerning side rails were used as a restraint after getting her arm caught in the side rail on 8/21/15 or the padding to the side rails. A review of the Progress Notes dated 8/21/15 at	F 221	by going into every resident¿s room and determining what type of side rails, hi low or other potentially restraining devices were being used. This included bed rails, hi-low mattresses, Geri chairs, and other cushions that might be considered restraints. Once a device was determined to be attached or adjacent to the resident¿s body it was evaluated by the nurse to identify if it restricted the patients freedom of movement or normal access to the patient¿s body. Devices that were considered a restraint were then reviewed for medical necessity by the evaluating nurse. If the device was identified as a restraint and not medically indicated a reduction plan was established by the care planning team. This review was completed by 9/3/15. As of 9/3/2015 all patients have been evaluated and all restraining devices without medical necessity have been discontinued or have active reduction plans with specified time frames to accomplish the reduction. As a result of this review, 28 patients had changes in bedrail utilization. 11 patients that utilize either geri-chairs, hi low mattresses or other devices are being screened by therapy as the first step of their restraint reduction plan. Systematic Changes On 9/3/2015, the QA Nurse Consultant, in-serviced all nurses managers (unit managers, MDS, SDC and DON) on restraints. Topics included: ¿ Many devices can be a restraint for a patient. For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest	

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F 221	Continued From page 8 11:10 AM Nurse #6 was called to Resident #160 ' s room by her roommate ' s family member. Documentation revealed the resident was found sitting on the floor beside her bed with her left arm caught in the side rail. The nurse documented that the family member stated that she and another visitor observed her moving about in her bed and " squirmed " until she had her feet off the side of the bed and when her feet touched the floor, her sock feet slid. The nurse further documented the family member stated Resident #160 was holding onto the side rail and when she slid to the floor her arm got caught in the side rail. The nurse assessed her for injuries and the resident was helped back into bed with her arm only being assessed as red and with no break in the skin. A review of the incident report dated 8/21/15 revealed Resident #160 was found sitting on the floor beside her bed with her left arm through the side rail. The predisposing physiological factors revealed the resident was confused, she had gait imbalance and impaired memory with her side rails up. There were 2 witnesses both visitors. Interventions were to have side rails padded and nonskid socks to be applied to the resident. Documented on the incident report revealed the revision day was 8/24/15 A review of the Progress Notes dated 8/31/15 at 11:49 AM revealed that half rail padding was added to Resident #160 ' s side rails in the morning (8/31/15). During an observation on 8/31/15 at 2:33 PM Resident #160 was observed in her bed with padded side rails. The padding was observed with the ends of the padding extending 2 to 3	F 221	restraint or wrist restraints but restraints can be anything that limits a patient¿s ability to move. ¿ The official definition of a physical restraint is according to the State Operation Manual was reviewed with staff. Emphasis was put on the fact that bedrails, hi-low mattresses and geri-chairs can be considered restraints. ¿ Device evaluation forms must be completed on all patients on admission, readmission, every 6 months and with significant changes. Additionally any time a resident has fall where a device was utilized the device must be evaluated to ensure that the device does not pose a hazard to the patient. A device evaluation form should be completed to document this review in the medical record. The device evaluations should look at all devices that the patient uses that may meet the definition of a restraint listed above. If the device is considered a restraint then the medical necessity of the device is reviewed. If the device is medically necessary then the interdisciplinary care plan team should review the device to try and reduce or eliminate the use of the restraint. Reduction plans should be reviewed every week during the daily clinical meeting to ensure that the restraint is being reduced. This must continue until the restraint is discontinued. On 9/3/15 the nurse managers began in-servicing all current nursing staff (RN, LPN, NA both full time and part time regarding the use of devices and side	

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F 221	Continued From page 9 inches over the side rails. During an interview on 9/1/15 at 3:08 PM the resident ' s Nursing Assistant (NA#11) stated Resident #160 was moving around in bed and stuck her feet out of bed and fell getting her arm caught in the side rail. She had half rails and they placed a cushion on top of the rails so that she would not get her arm caught in the side rails. On 9/1/15 at 3:25 PM Nurse #6 stated that she assessed Resident # 160 on 8/21/15. Nurse #6 stated the resident slipped out of the bed onto the floor. She stated Resident #160 had been moving about in the bed she moved over on the side of the bed. She stated the roommate ' s family member told her that Resident #160 was holding onto the side rail and she slid down onto the floor and her left arm slid into the side rail. Nurse #6 stated as staff were getting her off the floor they got her arm out of the side rail. Nurse #6 stated she assessed the resident and her left upper arm was a little red but she had no skin tears. On 9/1/15 at 5:12 PM the roommate ' s family member stated she was in Resident #160 ' s room on the day she saw Resident #160 have her left arm stuck in the side rail (8/21/15). She stated she visited every day and Resident #160 usually stuck her arm through the side rail. She stated on the day of the incident (8/21/15) the resident had her body wrapped up in a sheet. Resident #160 was squirming and slid out of bed and she fell down on her knees. The family member stated as Resident #160 was observed falling out of bed she got her left arm stuck in the side rail. The family member stated the resident stated her knees were hurting and she went and	F 221	rails. The Director of Nursing will ensure that any employee who has not received this training by 9/3/15 will not be allowed to work until the training is completed. As of 9/3/15 approximately 50 % of employees have received this training. This in-service included the following topics: ¿ There are lots of reason why we should not use a restraint. Studies have shown that restraints do not prevent falls and can actually cause harm to a patient. This harm can include fractures, skin injuries, or even death by strangulation. The survey guidelines that regulate skilled nursing facilities also include regulations that protect the resident¿s right against being restrained. ¿ Restraints can include a physical restraint or chemical restraint (medications). For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient¿s ability to move. The official definition of a physical restraint was reviewed during the in-service. ¿ If a patient uses one of those devices we need to ensure that the device is not a hazard for the patient. If you notice the patient throwing their legs over the rails or gerichair, notify the charge nurse immediately. The charge nurse should ensure that the nurse manager is notified. The nurse manager will need to complete a device or side rail evaluation to ensure that the device is still medically necessary or they will need to make efforts to	

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(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 221	Continued From page 10 got someone to help her. She stated she observed staff lifting her up and saying for them to be careful getting her arm out of the rail. She stated the facility just put the cushion over the side rail yesterday (8/31/15). On 9/2/15 at 8:41 AM the Rehab Manager stated Resident #160 was admitted to the facility for Physical Therapy. Her therapy began on 5/12/15 and ended on 6/2/15 due to she was at her maximum potential. Rehab staff addressed transfers and gait and she was able to ambulate with assistance. She could transfer to and from the bed to the wheelchair with minimal assistance. She was inconsistent and had cognition impairment and could not remember from day to day. She was assessed as being able to stand 2 minutes with contact guard assistance, but could not stand by herself. She always required some assistance. She was discharged on 6/2/15 due to she was at her maximum potential. Rehab staff did receive a referral in July 2015 and made attempts to pick her up for therapy but she was very aggressive and had cognitive impairment. The Rehab Manager stated, " We did not evaluate her regarding the side rails. " During an interview on 9/2/15 at 9:41 AM with the MDS Coordinator stated she had been involved with the Unit Manager, the Director of Nursing (DON), and the Administrator after the fall on 8/21/15. She stated they had decided to put a cushion over the side rail but there were no cushions available and they had to order a cushion that came in on 8/31/15. She stated they had nothing else in place to prevent her from getting her arm stuck through the side rails again. The MDS Coordinator further stated that she did	F 221	remove the device. ¿ The survey manual says: Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident¿s unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints. ¿ As you can see there are very few situations where restraints should be used. ¿ In general when dealing with a patient who is agitated there are some basic steps you can follow to try and reduce the agitation. They include active listening, provide reassurance, provide activities, modify the environment, find other outlets for the patient and check yourself ensuring your approach is calm and reassuring. ¿ Each patient is unique and interventions to minimize the risk of falling may range from offering favorite foods to playing music or a TV program that they may like. The patient¿s care plan will include interventions that should be used to try to calm the patient. The physician should also be notified so that medical interventions can be explored if the care plan interventions do not work or if the agitation is more severe than usual. If interventions listed in the care plan do not work and the physician cannot provide	

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F 221	Continued From page 11 not think the side rails were hazardous or they were a restraint because the resident could get out of bed even though she was not safe. During an interview on 9/03/15 at 2:04 PM Resident #160 ' s responsible party stated that the facility had called her about 2 weeks ago and told her that her roommate ' s family member had reported that Resident #160 had gotten tangled up in the covers, slid off the bed and got her left arm caught in the side rail. She stated staff had told her that she did not have any bruising. While talking to the responsible party she was observed lifting the sleeve from her left arm and there was no bruising observed. She was then observed lifting the sleeve of her right arm. Resident #160 ' s arm was observed with a dark purple bruise approximately 2 inches long and 1 inch wide. The responsible party stated her arm looked like the side rail had bruised her. The responsible party asked Resident #160 how she got the bruise and she stated she got her arm caught in the side rail. During an interview on 9/3/15 2:06 PM Nurse #7 stated she was not aware of her having a bruise and asked Resident #160 how she had gotten the bruise and she stated she got her arm caught in the side rail. On 9/3/15 2:23 PM with Nurse #7 and NA #12 present, NA #12 stated that she was assigned to be Resident #160 ' s NA on 9/3/15 and saw the bruise while she was bathing her at 7:30 AM. NA #12 stated she asked the resident how she thought it happened and Resident #160 told her she hurt it in the side rail. Nurse #7 stated the area looked like an older bruise that happened several days ago. She stated it did look like the	F 221	additional directions, then notify the DON or nurse manager on call. ¿ Anytime a patient is actively trying to get up unassisted or if they are trying to get out of a gerichair unassisted or throwing their legs over a side rail, one on one supervision must be implemented. Staffing should be reallocated to cover all patients until additional assistance can be called in to cover the one on one supervision. Your charge nurse should contact the administrator and DON immediately if a patient meets this criteria and to get assistance in coordinating the staffing needs. The administrators and DON phone numbers are listed at the nursing station. One on one supervision should be continued until the patient is reviewed by the Quality Assurance team and alternative safety interventions are identified and implemented. The QA team should ensure that the complete a device evaluation or a siderail evaluation is completed. Also make sure to document the restlessness and any fall in the electronic health record. To assist in fall prevention make sure to include any devices (gerichair, bedrail. Bolster mattress or restraint) that was in use. ¿ Restraints do not provide safety for our patients and should only be used in extreme emergencies. Restraints can be both physical and chemical. Physician restraints may be items not typically thought of as a restraint such as a sheet or chairs. It depends on how the device is used and why we are using it. If you are caring for an agitated patient who is trying to get up unassisted please refer to the	

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F 221	Continued From page 12 bruise was from the side rail on her upper right arm. During an interview on 9/4/15 at 11:56 AM the Director of Nursing (DON) stated that she had been a part of the clinical meeting concerning Resident #160 ' s 8/21/15 fall. The DON stated she met with the Administrator, the Unit Manager and the MDS Coordinator. They discussed that the resident ' s arm did get caught in the side rail and they ordered padding to go over the rail. The DON stated that the roommate ' s family member told her that Resident #160 slid out of the bed using the side rail to hold on to and when her feet touched the floor she did not have on non-skid socks and slid getting her arm caught through the side rail. The DON stated she did not have any witness statements from the investigation and the incident report was what they used to discuss the fall. The DON further stated that her definition of a restraint was if it prohibited them from having normal access to their body or perform an activity they wanted to perform then it was a restraint. She further stated she had been told the resident has a " right to fall. " When the DON was asked if she was aware that when a resident got their arm caught through a side rail while exiting her bed, she was at risk for injury, the DON stated that side rails can be hazardous but she had assessed Resident #160 ' s side rails as an enabler to help her move in her bed. The DON stated that because the facility had coded her side rails as an enabler they did not have a physician ' s order for side rails. The DON stated she was still investigating why Resident #160 had the bruise on her right upper arm. The DON stated they did order the side rail cover to avoid her getting her arm stuck in the side rail again. She stated she was not aware that the padding	F 221	care plan for interventions to minimize the agitation. If they do not work contact the physician. One on one supervision may also be necessary for patient safety. ¿ If you have questions please contact your DON or Nurse Supervisor for clarifications. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed started 9/2/15. Quality Assurance The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Monitor for devices for restraints. The monitoring will review all admissions to ensure that a device evaluation was completed on admission and any time a device is involved in an accident or fall. This will be completed on all admissions and incident reports weekly times 4 weeks Monday thru Friday in Daily QOL then on 10 admissions/incident residents with devices monthly times 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager. Immediate Jeopardy Removal Date : 9/3/2015	

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F 221	Continued From page 13 did not come until 8/31/15 and would have expected her staff to let her know if the padding was not available for that long. 2. Resident #78 was admitted to the facility on 10/16/12 and re-admitted on 11/10/14 with diagnoses including Senile Dementia, History of fall, History of Intracranial injury, Osteoarthritis, Anxiety, and aftercare for healing traumatic fracture of hip. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 8/20/15 identified Resident #78 as moderately cognitively impaired (Brief Interview for Mental Status (BIMS) of 9). Resident #78 had no behaviors. She required extensive two person assistance with bed mobility and transferring. She did not walk in her room or hallways. Balance during transitions and walking was coded as 8 - activity did not occur. She had no range of motion limitations. She did not use a cane/crutch/walker or wheelchair for mobility. She received anti-anxiety and anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were not coded as being used. Review of most recent care plan dated 10/29/14, with a revised goal target date of 11/14/15, for use of side rails identified the Focus area as: ½ (half) side rails to both sides of the bed to enable the resident to maintain as much independence with bed mobility as possible, with increased risk for complications. Interventions in meeting the goal of minimizing the risks for complications related to the use of side rails included, in part: periodically (at least quarterly) reassess for continued need for use of side rail and report to the nurse immediately if resident was noted	F 221		

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F 221	Continued From page 14 between the rail and the bed. Review of the Side Rail Assessment dated 5/10/15 read the resident was unable to state her preference about the side rails. The side rails were ½ (half) rails in length on both sides of the bed. The resident had a history of falls, had no history of falls from bed, did not attempt to get out of bed climbing over or around rails, she was mobile in the bed, she did not turn side to side, had made no attempts made to get out of bed, and had difficulty with balance/trunk control and decreased safety awareness. The side rail decision was to continue with the current side rail usage. During an observation on 8/31/15 at 2:30 PM Resident #78 was noted to be in her bed with ½ (half) side rails in the up position on both sides of the bed. The rails had a top and bottom rail with an approximate 4 inch tap between the bottom and top rail. There was approximately 16 " from top of bed to the start of side rail which was then approximately 2 foot long. The mattress was a high-low mattress with the upper and lower portion of the mattress high and a portion in the middle of the mattress lower. The side rail was observed to be placed next to the low area of the hi-low mattress. There was an alarming fall mat on the floor next to the bed. The resident was observed to have her left leg over the side rail and her right leg through the top portion of the side rail lying horizontal in her bed with her head in the direction of the wall. The bed was pushed against the wall. She was alert but not oriented. During an observation on 8/31/15 at 5:12 PM Resident #78 was asleep in her bed with legs observed in bed. The half side rails were in the up position on both sides and an alarming fall mat was on floor. During an interview with Nurse #5 on 9/1/15 at	F 221		

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F 221	Continued From page 15 3:48 PM she stated that Resident #78 can turn from side to side in bed, is not supposed to get up on her own and has an alarming fall mat. She continued by stating that once in a while Resident #78 will hang her legs over the bed but there are alarms if she gets up. During an interview on 09/01/2015 3:51 PM with Nursing Assistant #4 she stated that the resident can move around in the bed and turn side to side. She has alarms on the bed and the fall mat because of a previous fall and fractured hip. She stated Resident #78 has no range of motion limitations. She stated she thought the facility left the alarms on because Resident #78 use to get out of bed unassisted. During an interview with Nurse #3 on 9/2/15 at 9:25 AM she stated that on 6/19/15 the resident was fighting and attempting to get out of bed so she notified the Physician. She stated trying to get out of bed by scooting to bottom of the bed to exit. During an interview with the MDS Nurse on 09/01/2015 4:08 PM she stated Resident #78 does move around bed and roll side to side. She will not roll on command but she will move in the bed. She has a pressure alarm and fall mat alarm because of her history of falls. During an observation on 9/1/15 at 4:52 PM Resident #78 was observed with her right leg out of the bed wedged between the hi-low mattress and the side rail trying to get up out of the bed. Nurse #5 was made aware and entered the resident ' s room. During an interview on 9/1/15 at 4:55 PM with Nurse #5 stated upon entering Resident 78s room, " this is why we keep the alarms because she tries to get out of bed. " Nurse #5 then took the resident ' s leg and stated to the resident, let '	F 221		

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F 221	Continued From page 16 s get your leg up here and turn you back in bed. During an interview with the MDS Nurse on 9/2/15 at 9:00 AM she stated that the care plan for side rails read to notify the nurse if the resident is between the rail and bed because the old beds use to have " a gap " between the rails and the bed and residents could get stuck. She stated now that note remains on the care plan as a precaution. She further stated the alarms are evaluated but Resident #78 still "moves a lot" so it is better if she has alarms. She stated she will roll in bed and move from side to side. While in Geri chair she will throw her legs over the arms and this makes me think she could throw legs over bed rail. The MDS Coordinator stated that Resident #78 would not know where to get up if she decided to get up, whether it be the top, middle or bottom of bed. During a follow up interview with the MDS Nurse on 9/2/15 at 9:13 AM she stated that she did not consider the hi-low mattress or side rail a restraint because the resident could still get out of them, even though not safely. She stated that she never realized that if a resident attempted to get up, even unsafely, that this would be considered a restraint During an interview with Director of Nursing on 9/2/15 at 9:44 AM she stated that she did not feel the hi-low mattress and side rails were restraints but enablers and boundaries. She stated she believed the alarms, hi-low mattress and side rails have just " stayed " in place because Resident #78 used to attempt to get out of bed unassisted. Resident #78 was observed on 9/3/15 at 2:00 PM. She had a low bed, high-low mattress and bed and fall mat alarms in place. The side rails had been removed.	F 221		

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F 221	Continued From page 17 During an interview with the Director of Nursing (DON) on 9/4/15 at 11:56 AM she stated that putting arms and legs through or around side rails is hazardous behavior and had she been aware she would have acted immediately on the situation. The Administrator was notified of the Immediate Jeopardy on 9/2/15 at 3:06 PM. The Immediate Jeopardy was removed on 9/4/15 at 3:30 PM based on the Credible Action Plan. Interventions listed on the plan included: WHAT MEASURES WERE PUT INTO PLACE FOR THE REDIENT AFFECTED: For Resident #160 on 9/3/15 the bedrails were removed from the bed as a results of the side rail assessment completed on 9/3/15 by the care plan team. 9/3/15 a bruise was located on the right arm where the staff, family, resident interviews stated that it came from the side rail. The physician was notified on 9/3/15 at 1:58 PM. He responded at 3:15 to monitor the bruise. For Resident #78 on 9/3/15 the care plan team evaluated the use of the hi-low mattress. The team decided to continue the use of the hi-low mattress and re-evaluate weekly for a maximum of 30 days since the side rail reduction has also occurred. The care plan team also completed a device evaluation related to the side rail and discontinued its use on 9/3/15 as a result of the evaluation. Resident #78 continues to use a Geri-chair when getting up and is positioned at the nurse ' s station for monitoring by staff. The patient will be re-evaluated by therapy to see if alternative seating arrangements can be made. WHAT MEASURES WERE PUT IN PLACE FOR RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED? On 9/3/2015 the QA Nurse Consultant, in-serviced all nurses managers (unit managers,	F 221		

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F 221	Continued From page 18 MDS, SDC and DON) on restraints. Topics included: · Many devices can be a restraint for a patient. For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient ' s ability to move. · The official definition of a physical restraint is according to the State Operation Manual is was reviewed with staff. Emphasis was put on the fact that bedrails, hi-low mattresses and Geri chairs can be considered restraints. · Device evaluation forms must be completed on all patients on admission, readmission, every 6 months and with significant changes. Additionally any time a resident has fall where a device was utilized the device must be evaluated to ensure that the device does not pose a hazard to the patient. A device evaluation form should be completed to document this review in the medical record. The device evaluations should look at all devices that the patient uses that may meet the definition of a restraint listed above. If the device is considered a restraint then the medical necessity of the device is reviewed. If the device is medically necessary then the interdisciplinary care plan team should review the device to try and reduce or eliminate the use of the restraint. Reduction plans should be reviewed every week during the daily clinical meeting to ensure that the restraint is being reduced. This must continue until the restraint is discontinued. On 9/3/15 the nurse managers began in-servicing all current nursing staff (RN, LPN, NA both full time and part time regarding the use of devices and side rails. The Director of Nursing will	F 221		

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ensure that any employee who has not received this training by 9/3/15 will not be allowed to work until the training is completed. As of 9/3/15 approximately 50 % of employees have received this training. This in-service included the following topics:

· There are lots of reason why we should not use a restraint. Studies have shown that restraints do not prevent falls and can actually cause harm to a patient. This harm can include fractures, skin injuries, or even death by strangulation. The survey guidelines that regulate skilled nursing facilities also include regulations that protect the resident ' s right against being restrained.

· Restraints can include a physical restraint or chemical restraint (medications). For something to be a restraint it depends on why and how we use it. We typically think of a restraint being a vest restraint or wrist restraints but restraints can be anything that limits a patient ' s ability to move. The official definition of a physical restraint was reviewed during the in-service.

· If a patient uses one of those devices we need to ensure that the device is not a hazard for the patient. If you notice the patient throwing their legs over the rails or Geri chair, notify the charge nurse immediately. The charge nurse should ensure that the nurse manager is notified. The nurse manager will need to complete a device or side rail evaluation to ensure that the device is still medically necessary or they will need to make efforts to remove the device.

· The survey manual says: Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical

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treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident ' s unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints.

· As you can see there are very few situations where restraints should be used.

· In general when dealing with a patient who is agitated there are some basic steps you can follow to try and reduce the agitation. They include active listening, provide reassurance, provide activities, modify the environment, find other outlets for the patient and check yourself ensuring your approach is calm and reassuring.

· Each patient is unique and interventions to minimize the risk of falling may range from offering favorite foods to playing music or a TV program that they may like. The patient ' s care plan will include interventions that should be used to try to calm the patient. The physician should also be notified so that medical interventions can be explored if the care plan interventions do not work or if the agitation is more severe than usual. If interventions listed in the care plan do not work and the physician cannot provide additional directions, then notify the DON or nurse manager on call.

· Anytime a patient is actively trying to get up unassisted or if they are trying to get out of a Geri chair unassisted or throwing their legs over a side rail, one on one supervision must be implemented. Staffing should be reallocated to cover all patients until additional assistance can be called in to cover the one on one supervision. Your charge nurse should contact the administrator and DON immediately if a patient

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F 221	Continued From page 21 meets this criteria and to get assistance in coordinating the staffing needs. The administrators and DON phone numbers are listed at the nursing station. One on one supervision should be continued until the patient is reviewed by the Quality Assurance team and alternative safety interventions are identified and implemented. The QA team should ensure that the complete a device evaluation or a side rail evaluation is completed. Also make sure to document the restlessness and any fall in the electronic health record. To assist in fall prevention make sure to include any devices (Geri chair, bedrail. hi low mattress or restraint) that was in use. · Restraints do not provide safety for our patients and should only be used in extreme emergencies. Restraints can be both physical and chemical. Physician restraints may be items not typically thought of as a restraint such as a sheet or chairs. It depends on how the device is used and why we are using it. If you are caring for an agitated patient who is trying to get up unassisted please refer to the care plan for interventions to minimize the agitation. If they do not work contact the physician. One on one supervision may also be necessary for patient safety. · If you have questions please contact your DON or Nurse Supervisor for clarifications. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed started 9/2/15. The Credible Action Plan was verified by: 1. Record review of In-Service Education content and sign in sheets. 2. Interviews on 9/4/15 at 1:20 PM through	F 221		

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F 221	Continued From page 22 9/4/15 at 3:30 PM with Nurses, Unit Managers and Nursing Assistants on all halls for both first and second shift confirming recent in-service. 3. For Resident #160 on 9/3/15 the side rails were removed from the bed as a results of the side rail assessment completed on 9/3/15 by the care plan team. Resident #160 was observed without her side rails 4. For Resident #78 on 9/3/15 the care plan team evaluated the use of the hi-low mattress. The team decided to continue the use of the hi-low mattress and reevaluate weekly for a maximum of 30 days since the side rail reduction has also occurred. The care plan team also completed a device evaluation related to the side rail and discontinued its use on 9/3/15 as a result of the evaluation. Resident continues to use a Geri-chair when getting up and is positioned at the nurse ' s station for monitoring by staff. The patient will be re-evaluated by therapy to see if alternative seating arrangements can be made. 5. A review of the list of residents with side rail evaluations and that the evaluation was implemented. Observations were conducted on all halls to assure the side rail evaluations were implemented. 3. Resident #78 was admitted to the facility on 10/16/12 and re-admitted on 11/10/14 with diagnoses including Senile Dementia, History of fall, History of Intracranial injury, Osteoarthritis, Anxiety, and aftercare for healing traumatic fracture of hip. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 8/20/15 identified Resident #78 as moderately cognitively impaired (Brief Interview for Mental Status (BIMS) of 9). Resident #78 had no behaviors. She required extensive two person assistance with	F 221		

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F 221	Continued From page 23 bed mobility and transferring. She did not walk in her room or hallways. Balance during transitions and walking was coded as 8 - activity did not occur. She had no range of motion limitations. She did not use a cane/crutch/walker or wheelchair for mobility. She received anti-anxiety and anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were not coded as being used. Review of the Care Area Assessment Summary dated 10/1/14 for falls triggered related to balance problems during transitioning, at least one fall since admission and she received antidepressants and antianxiety medications seven days per week. Considerations listed in developing a care plan documented Resident #78 remained at an increased risk for falls due to frequent attempts to get out of bed unassisted, along with increased confusion at times. The staff were to monitor the resident for any attempts to get up unassisted or any other factors that may have contributed to a fall and intervene as needed to prevent falls from occurring. Review of the revised care plan dated 10/29/14 for falls identified the Focus area as Resident #78 being at risk for falls related to Confusion, Psychoactive drug use, history of falls and frequent attempts to get up unassisted. Interventions in meeting the goal of minimizing the risk of falls included, in part, re-educating the staff on fall precautions, the need for the resident to be in view of staff while up in Geri chair, educating staff to keep resident at nurses station when in Geri chair and to put her in bed if in her room, personal alarm in place, chair alarm in place, floor mat alarm in place and bed alarm in place while in bed. Review of the Occupational Therapy (OT) screen	F 221		

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F 221	Continued From page 24 dated 9/25/14 for screening for positioning safety in Geri chair documented secondary to cognition, the resident attempts to stand and required supervision and the resident did not have the potential to improve functional independence or position because of sitting long in the Geri chair. The recommendation read, patient appeared agitated and trying to get out/stand up from Geri chair possibly due to cognitive/Dementia deficits. No skilled OT recommended at this time. Review of the Occupational Therapy screen dated 10/6/14 for wheelchair positioning (Geri chair) documented that Resident #78 had cognitive deficits and confusion. The recommendation read that the resident had cognitive impairments and attempted to get out of the Geri chair and required supervision from staff. During an interview with the Rehabilitation Manager on 9/3/15 at 10:00 AM she stated that Resident #78 was screen on 9/25/14 because the resident appeared agitated and was trying to get up out of her Geri chair. She stated that the therapist who saw Resident #78 was a PRN (as needed) therapist and not working. She further stated that this information would have been communicated to nursing. She continued by stating the resident was seen again on 10/6/14 for Geri chair positioning after a fall from the chair and on this date it was again noted the resident had cognitive impairment and attempted to get out of the Geri chair and supervision was required. During an interview with the Minimum Data Set (MDS) Nurse on 9/2/15 at 9:00 AM she stated that while Resident #78 is in the Geri chair she would throw her legs over the side. During a follow-up interview with the MDS Nurse on 9/2/15 at 9:13 AM she stated that she did not consider the Geri chair a restraint because the	F 221		

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F 221	Continued From page 25	F 221		

resident could still get up out of the chair, even though not safely. She stated the resident cannot follow commands and she never realized that if a resident attempted to get up unsafely that this would be considered a restraint. She stated this was the reason the " chair that prevents rising " was not checked as a restraint on the MDS assessment.

Review of the Fall report dated 10/28/14 documented Resident #78 was found by the nurse, after hearing the personal alarm, sitting upright on her buttocks on the floor in her room approximately six inches from the chair. Resident #78 only stated " I can ' t get up, I can ' t get up. " She was assessed for injuries and assisted back to bed. The intervention listed was to re-educate the staff to keep resident in view when in her Geri chair.

Review of the Nursing Progress Note dated 10/28/14 documented that Resident #78 was found sitting on the floor of her room. The personal alarm was sounding. She was unable to state what happened, only saying, " I can ' t get up " over and over again. No injuries were noted and the resident was assisted to bed.

During an interview with the Director of Nursing (DON) on 9/2/15 at 9:10 AM she stated that the fall report of 10/28/14 read to re-educate the staff on placing the resident in view because Resident #78 gets up unassisted and the staff need to be reminded to place her in view. She further stated that she was not the DON when Resident #78 fell on 10/6/14 and did not have an answer as to what was done to protect Resident #78 from having another fall from the Geri-chair.

During an interview with Nursing Assistant #1 on 9/3/15 at 3:05 PM, who worked with Resident #78 on 10/28/15 during the 3 PM - 11 PM shift, she stated that she put Resident #78 to bed

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F 221	Continued From page 26 sometime after dinner. She remembered that the resident was restless. She stated she laid Resident #78 down and left the room to check on another resident. She stated when she came back down the hall she heard the alarm going off and went into the resident ' s room and Resident #78 was sitting up on the side of the bed like she was going to get up. NA #1 told the resident it was time to go to sleep. NA #1 stated that it was clear to her Resident #78 was not going to lay down so she put her back into the Geri chair. She stated she set the alarms and leaned the chair back with her feet up. She further stated she always put the chair in a reclining position and elevated the feet. During an interview with Nurse #1 on 9/3/15 at 3:30 PM, it was stated that on the evening of 10/28/14 she was passing medications when she heard Resident #78 talking and her alarm sounding. She entered the room to find the resident sitting on the floor. She stated the resident had been in her Geri-chair. She stated the resident was not complaining of pain and she assessed the resident and everything looked fine. She had another nurse (Nurse #2) help return the resident to her bed. She stated the resident was picked up and placed in bed. Review of the Nursing Progress Noted dated 10/29/1/4 it was documented Resident #78 was sitting in the Geri chair in her room. During an observation on 9/2/15 at 8:35 AM the resident was out of bed in her Geri chair in her room feeding herself breakfast. During an interview with the DON on 9/4/15 at 11:56 AM she stated she was unaware who decided on the use of a Geri chair for Resident #78. She stated when the resident was admitted to the facility she shuffled her feet and the facility tried grip slips and this did not work. She	F 221		

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F 221	Continued From page 27 continued to state as far as a fall out of the Geri chair on 10/6/14 she was not the DON at the time and was unaware that the resident was throwing her legs over the Geri chair. She stated if she had seen or known she was throwing her legs over her side rail or Geri chair it would have been said to be a restraint. She stated the staff were not aware that this would have been a restraint, even though education had been done and they were unaware to notify the DON for this behavior. She stated she could not answer why the resident ' s Geri chair was not determined a restraint on 10/6/15. She stated, at this time, if a resident is in a Geri chair and falls out, the chair would be considered a restraint because it prohibited the resident performing an activity they wanted to perform. She stated that a resident has a right to fall and with that knowledge the facility now knows that Geri chairs can be restraints. She stated behaviors such as throwing legs over Geri chairs are hazardous and if she had been aware she would have acted on this. Review of the Nursing Note dated 11/4/14 documented the nurse entered the resident ' s room for morning medication pass at 7:40 AM and the resident started to complain of left leg and hip pain and yell out in severe pain. The left thigh was swollen and the left leg shorter than the right leg. The physician was notified and an order received to send the resident to the emergency room for evaluation. Review of the Nursing Progress Note dated 11/4/14 documented the resident was admitted to the hospital with a left Proximal Femur fracture. Review of the Hospital x-ray report dated 11/4/14 documented a fracture proximal left femur. Review of the Hospital physical exam dated 11/4/14 documented the chief complaint as hip pain. The left leg was short and rotated. She had	F 221		

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F 221	Continued From page 28 decreased range of motion of the left lower extremity secondary to the fracture. She had some bruising on the legs. Review of the Hospital discharge summary dated 11/10/14 listed the discharge diagnoses as left hip fracture, status post ORIF (open reduction internal fixation).	F 221		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide a sanitary environment by failing to clean the tube feeding poles of feeding formula for 2 of 2 sampled residents. (Resident # 54 and # 140). The findings included: 1. Resident # 54 was admitted to the facility on 3/04/10 with diagnoses including Cerebrovascular Accident, aphasia and seizure disorder and was receiving Glucerna 1.5 via a gastrostomy tube. On 8/31/15 at 4:45 PM in Room # 503 the top of the feeding pump and face was observed with 6 dime size light tan drops of dried matter. The feeding pole base and the floor around the base of the tube feed pole was observed with 12 to 17 dime and nickel sized light tan drops of dried matter. On 9/1/15 at 3:39 PM in Room # 503 the top of the feeding pump and face was observed with 6 dime size light tan drops of dried matter. The feeding pole base and the floor around the base	F 253	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility¿s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 253 Corrective Action for Resident Affected For resident #54 and #140 the tube feeding pump, pole, and floor beneath were cleaned by the Housekeeping staff on 9/4/2015.	10/2/15

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F 253	Continued From page 29 of the tube feed pole was observed with 12 to 17 dime and nickel sized light tan drops of dried matter. On 9/2/15 at 1:59 PM in Room # 503 the top of the feeding pump and face was observed with 6 dime size light tan drops of dried matter. The feeding pole base and the floor around the base of the tube feed pole was observed with 12 to 17 dime and nickel sized light tan drops of dried matter. On 9/3/15 at 9:44 AM in Room # 503 the top of the feeding pump and face was observed with 6 dime size light tan drops of dried matter. The feeding pole base and the floor around the base of the tube feed pole was observed with 12 to 17 dime and nickel sized light tan drops of dried matter. During an interview with the 200 hall Housekeeper on 9/3/15 at 9:44 AM she stated that she wiped down and dusted the furniture, cleaned the bathroom, emptied trash, mopped and wiped down the tube feeding poles. During an interview with the Administrator on 9/4/15 at 10:19 AM she stated that she would expect the tube feeding pumps and poles to be clean and staff would clean them. 2. Resident # 140 was readmitted to the facility on 7/28/15 with diagnosis including Protein Calorie Malnutrition, Chronic Kidney Disease and was receiving Glucerna 1.5 at 40 cc/hour via a gastrostomy tube. On 9/2/15 at 11:03 AM in Room # 207 the front of the feeding pump was observed with 4 dime size light tan drops of dried matter and where the feeding lines met the feed wheel was observed with light tan drops of dried matter. On 9/3/15 at 9:06 AM in Room # 207 the front of the feeding pump was observed with 4 dime size light tan drops of dried matter and where the	F 253	Corrective Action for Resident Potentially Affected All resident with feeding poles have the potential to be affected. All current residents that utilize a feeding pole and pump were audited on September 4, 2015 for dried matter or debris on their feeding pole, pump and floor beneath. This was completed by the Administrator. No concerns were identified with this audit. Systemic Changes Effective September 25, 2015 the daily cleaning of the tube feeding poles was assigned to the housekeeping department. On September 23 and 24, the Housekeeping Department employees FT, PT and PRN were in-serviced on policy number HSK-110 by the Administrator. The topics included: When cleaning horizontal Surfaces. Clean and dust using germicidal cleaner: Tube feeding poles, Tube feeding pump, and floors beneath the tube feeding pole, window sills, bed rails, headboards, tables, chairs dressers, and beside tables. Any in-house staff member who did not receive in-service training by October 2, 2015 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all Housekeeping employees and will be	

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F 253	Continued From page 30 feeding lines met the feed wheel was observed with light tan drops of dried matter. During an interview with the 200 hall Housekeeper on 9/3/15 at 9:44 AM she stated that she wiped down and dusted the furniture, cleaned the bathroom, emptied trash, mopped and wiped down the tube feeding poles. During an interview with the Administrator on 9/4/15 at 10:19 AM she stated that she would expect the tube feeding pumps and poles to be clean and staff would clean them.	F 253	reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Staff Development Coordinator will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Tube Feeding Poles. The monitoring will include assessing tube feeding pumps, poles and the floors beneath for any signs of dried matter or other debris. This will be completed on a sample of 5 residents¿ a week x 2 weeks then monthly for 3 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		10/2/15

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F 280	Continued From page 31 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and family interviews and observations the facility failed to update the care plan for a resident with falls (Resident #160) for one of two residents reviewed for accidents. Findings included: Resident #160 was admitted to the facility on 5/8/15 with diagnoses of hypertension, non-Alzheimer ' s Dementia with behaviors disturbances and with a history of falls. Resident #160 ' s last side rail assessment was completed on 5/8/15. Resident #160 was unable to state preference about her side rails. She was assessed to have ½ length side rail on both sides. She was assessed as having a history of falls and was mobile while in bed. She did have enough mobility to turn from side to side but had not attempted to get out of bed. She was assessed as having a decreased safety awareness due to confusion or judgment	F 280	F 280 Corrective Action for Resident Affected: For Resident #160, the residents care plan was reviewed and was noted to reflect her current fall interventions including personal alarm updated 05/11/15, bed alarm updated 05/11/15, and the side rail was discontinued on 09/03/15 and padded side rails had previously been updated to the care plan 08/23/15 and resolved on 09/03/15. This was completed by the MDS Coordinator. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this alleged deficient practice. Beginning 09/28/15 the nurse managers began reviewing all current residents who	

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F 280	Continued From page 32 problems. Staff decision was for her to continue current side rail usage. A review of the Progress Notes dated 5/8/15 revealed Resident #160 had a fall from her bed and was observed sitting on the floor. The facility for interventions had a urine analysis ordered and a personal and floor alarm were in place. A review of the Progress Notes dated 5/10/15 revealed Resident #160 had a fall and was observed lying on her back on the floor beside her roommate ' s bed. The personal alarm was attached to the bed Resident #160 was assessed as having a bruise measuring 2 centimeters (cm) by 2 cm on her left hip. The resident could not give a reason why she had gotten up unassisted. The facility for an intervention had a bed alarm added and therapy was initiated. A review of her care plan last up-dated 5/11/15 revealed Resident #160 was at risk for falls related to her being unaware of safety needs. She had poor communication and comprehension with gait and balance problems. The facility had interventions in place but none of the interventions concerning the personal, floor, bed alarms, side rails or padded side rails were included in the care plan. A review of the most recent quarterly Minimum Data Set (MDS) dated 8/15/15 and her admission MDS dated 5/15/15 revealed Resident #160 had short and long term memory problems. Resident #160 was coded as having verbal behavioral symptoms directed toward others and rejected care. She required extensive care for transfer and bed mobility with one person assist. She was not steady moving from a seated to standing position and moving form surface-to-surface transfer. She had impairment on both sides of her lower extremities. Bed rails, trunk restraint, limb restraint or chair that	F 280	have had a fall in the last 3 months. To accomplish this, the nurse managers printed a list of patients that had a fall incident report in the last 3 months. The incident report was then reviewed by the nurse managers to identify the interventions that were put in place. Interventions for the falls were then reviewed by the nurse manager to ensure that the interventions were appropriate and care planned and matched the MD orders. This process will be completed by 10/02/15. Systemic Changes On 09/21/15, the Corporate MDS Consultant in-serviced the Care Plan Team on reviewing and updating care plans. The in-service content included: Care plan updates. Care plans should be updated on an ¿ongoing¿ basis in order to reflect the most current condition/needs of the resident. This includes updating the care plan promptly after every falls review. Each discipline is responsible for making necessary updates to care plans as necessary so that it will reflect resident condition and needs. The Care Plan Team consisted of the MDS Coordinator, two Social Workers, Activities, and Dietary Manager. Any in-house staff member who did not receive in-service training by 10/02/15 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all Care Plan Team	

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	345218	A. BUILDING _____ B. WING _____	C 09/04/2015

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F 280	Continued From page 33 prevented rising were coded as not being used. A review of Resident #160 ' s Care Area Assessment (CAA) dated 5/21/15 revealed she triggered for behaviors and falls. Resident #160 had short and long term memory problems and a few episodes of refusing medications over the last week and yelling at a nurse (The assessment date was 5/15/15.) She was admitted to the facility after a fall from home for rehabilitation, strengthening and endurance. The facility proceeded to care plan due to behavioral symptoms and a history of falls. A review of the Progress Notes dated 8/21/15 at 11:10 AM Nurse #6 was called to Resident #160 ' s room by her roommate ' s family member. Documentation revealed the resident was found sitting on the floor beside her bed with her left arm caught in the side rail. The nurse documented that the family member stated that she and another visitor observed her moving about in her bed and " squirmed " until she had her feet off the side of the bed and when her feet touched the floor, her sock feet slid. The nurse further documented the family member stated Resident #160 was holding onto the side rail and when she slid to the floor her arm got caught in the side rail. The nurse assessed her for injuries and the resident was helped back into bed with her arm only being red and no break in the skin. A review of the incident report dated 8/21/15 revealed the facility ordered side rail pads and non-skid socks were already in place. A review of the Progress Notes dated 8/31/15 at 11:49 AM revealed that half rail padding was added to Resident #160 ' s side rails in the morning (8/31/15). On 9/1/15 at 5:12 PM the roommate ' s family member stated she was in Resident #160 ' s room on the day she saw Resident #160 have her	F 280	Members and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Monitor Care Plan Audit for monitoring updating care plans with new fall interventions as identified in QA and physician orders. This will be completed on all residents with falls weekly times 4 weeks then on 10 residents with falls monthly times 2 months or until resolved by QOL/QA committee. See Attachment A. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	

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F 280	Continued From page 34 arm stuck in the side rail (8/21/15). She stated she visited every day and Resident #160 usually stuck her arm through the side rail. She stated on the day of the incident (8/21/15) the resident had her body wrapped up in a sheet. Resident #160 was squirming and slid out of bed and she fell down on her knees. The family member stated as Resident #160 was observed falling out of bed she got her left arm stuck in the side rail. The family member stated the resident stated her knees were hurting and she went and got someone to help her. She stated she observed staff lifting her up and saying for them to be careful getting her arm out of the rail. She stated the facility just put the cushion over the side rail yesterday (8/31/15). During an interview on 9/2/15 at 9:41 AM with the MDS Coordinator stated she had been involved with the Unit Manager, the Director of Nursing (DON), and the Administrator after the fall on 8/21/15. She stated they had decided to put a cushion over the side rail but there were no cushions available and they had to order a cushion that came in on 8/31/15. During an interview on 9/4/15 at 11:56 AM the Director of Nursing (DON) stated that she had been a part of the clinical meeting concerning Resident #160 ' s 8/21/15 fall. The DON stated she met with the Administrator, the Unit Manager and the MDS Coordinator. They discussed that the resident ' s arm did get caught in the side rail and they ordered padding to go over the rail. She stated that the MDS Coordinator updated the care plan during the clinical meeting and should have updated the care plan after every intervention. The DON further stated that she did not know why the care plan had not been updated.	F 280		

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F 323	Continued From page 35	F 323		
F 323 SS=J	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 record review, observations, staff and family interviews the facility failed to assess residents for hazardous side rails for a resident that was observed by a family member attempting to get out of bed resulting in a fall with her arm stuck in the side rail and by failing to implement the side rail padding to prevent it from happening again (Resident #160) and for a resident observed attempting to get over the side rail with one leg through and one leg over the side rail and a second observation of the same resident with one leg wedged between the high-low mattress and side rail (Resident #78) for 2 of 2 residents (Resident #160 and Resident #78) with hazardous side rails. The facility also failed to provide supervision while she was left alone in a Geri chair resulting in a fall and femur fracture for 1 of 1 resident (Resident #78) reviewed for falls with a fracture. Immediate jeopardy (IJ) began on 8/21/15 at 11:10 AM for example #1(Resident #160). Immediate jeopardy began on 8/31/15 at 2:30 PM for example #2 (Resident #78). Immediate jeopardy was removed on 9/4/15 at 11:39 AM when the facility provided a credible allegation of	F 323	Credible Allegation for Tag 323 Corrective Action for Affected Residents Resident # 78 resident was sent to hospital on 11/04/2014 for evaluation of left hip and femur swelling. Resident returned to facility with status post ORIF (Open Reduction Internal Fixation). At that time resident was continued with fall precautions of hi low mattress, chair alarm, personal alarm, bed alarm, floor mat, and floor mat alarm. Resident continues to use a geri-chair when getting up and is positioned at the nurses station for monitoring by staff. The patient will be re-evaluated by therapy to see if alternative seating arrangements can be made. This will occur on 9/3/15. Additionally on 9/3/15 the care plan team evaluated the use of the hi low mattress. The team decided to continue the use of the hi low mattress and reevaluate weekly for a maximum of 30 days since the siderail reduction has also occurred. The care plan team also completed a device evaluation related to the side rail and	10/2/15

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F 323	Continued From page 36 compliance. Example #3 (Resident #78) was cited at a G (isolated deficiency that constitutes actual harm that is not immediate jeopardy). The facility will remain out of compliance at a scope and severity of level D (isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy). The facility was in the process of full implementation and monitoring their corrective action. The findings included: Example #1 Resident #160 was admitted to the facility on 5/8/15 with diagnoses of hypertension, non-Alzheimer ' s Dementia with behaviors disturbances and with a history of falls. Resident #160 ' s only side rail assessment was completed on 5/8/15. Resident #160 was unable to state preference about her side rails. She was assessed to have ½ length side rail on both sides. She was assessed as having a history of falls and was mobile while in bed. She did have enough mobility to turn from side to side but had not attempted to get out of bed. She was assessed as having a decreased safety awareness due to confusion or judgment problems. Staff decision was for her to continue current side rail usage. A review of the Progress Notes dated 5/8/15 revealed Resident #160 had a fall from her bed and was observed sitting on the floor. The nurse documented she was alerted to the resident ' s room by her personal alarm and Resident #160 was found on the floor. The facility ' s interventions included an order for urinalysis. She already had in place a personal alarm and a floor alarm (a floor mat that alarms when it is touched).	F 323	discontinued its use on 9/3/15 as a result of the evaluation. Resident has not had a fall since 10/28/14. Resident # 160 was admitted to the facility on 05/08/15. Resident fell on 05/08/15, a urine analysis was ordered and personal alarm and floor alarm was in place. Resident experienced a fall on 05/10/15 and bed alarm was added and therapy was initiated on 05/12/15. On 06/14/15 the resident fell and was placed at the nurses station with staff for close monitoring. On 07/25/15 the resident fell and a therapy screen was initiated. On 08/21/15 the resident fell and side rail pads were ordered and non-skid socks were put in place. On 9/3/15 the bedrails were removed from the bed as a result of the side rail assessment completed on 9/3/15 by the care plan team. 9/3/15 a bruise was located on the right arm where the staff, family, resident interviews stated that it came from the siderail. The physician was notified on 9/3/15 at 1:58 PM. He responded at 3:15 to monitor the bruise. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 9/2-3/15 the nurse reviewed all current patients who have had a fall in the last 12 months. To accomplish this the nurse managers printed a list of patients that had a fall incident report. The incident report was then reviewed by the nurse manager to identify the reason and/or contributing factors for the fall. This	

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F 323	Continued From page 37 A review of the Progress Notes dated 5/10/15 revealed Resident #160 had a fall from her bed and was observed lying on her back on the floor beside her roommate ' s bed. The personal alarm was attached to the bed. Resident #160 was assessed as having a bruise measuring 2 centimeters (cm) by 2 cm on her left hip. The resident could not give a reason why she had gotten up unassisted. The facility ' s new intervention included the use of a bed alarm and therapy was initiated. A review of her care plan last revised on 5/11/15 revealed Resident #160 was at risk for falls related to her being unaware of safety needs. She had poor communication and comprehension with gait and balance problems. The facility had interventions in place that included she needed a safe environment with her bed in low position and to monitor, document and report to the physician any signs and symptoms of bruising 72 hours after a fall. All interventions were started on 5/11/15 and there were no updates concerning the personal, floor, bed alarms or padding to the side rails. A review of the Physical Therapy notes dated 5/12/15 revealed Resident #160 received therapy beginning 5/12/15 and ended on 6/2/15 because she was at her maximum potential. Resident #160 was documented as able to ambulate with assistance and could transfer to and from the bed to the wheelchair with minimal assistance. She was inconsistent and had cognition impairment and could not remember from day to day. She always required some assistance. A review of Resident #160 ' s admission Minimum Data Set (MDS) dated 5/15/15 and her most recent quarterly MDS dated 8/15/15 revealed Resident #160 had short and long term memory problems. Resident #160 was coded as having	F 323	included reviewing falls for any indication that the bed rail contributed to the accident. Interventions for the falls were then reviewed by the nurse manager to ensure that the interventions were appropriate. Interventions may include alarms but also included medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning/strengthening exercises, increased supervision, one on one supervision, and other specifically related to the individual resident. Any incident involving a bed rail was also reviewed to ensure that the bed rail had been discontinued if no longer required by the patient. Any resident who was identified that did not have a falls prevention intervention or whose fall prevention intervention was not related to the specific fall was reviewed by the care planning team (nursing, social, activities and therapy) on 9/3/15 and interventions were identified and implemented as appropriate. Interventions may include alarms but also included medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning/strengthening exercises, increased supervision, one on one supervision, and other specifically related to the individual resident. Systematic Changes On 9/3/15 the QA Nurse Consultant, in serviced all nurses managers (unit managers, MDS, SDC and DON) on restraints. Topics included: ¿ Daily during clinical meeting all incident reports will be reviewed by the	

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F 323	Continued From page 38 verbal behavioral symptoms directed toward others and she rejected care. She required one person extensive assistance for transfer and bed mobility. She was not steady moving from a seated to standing position and moving from surface-to-surface. She had impairment on both sides of her lower extremities. Bed rails, trunk restraint, limb restraint or chair that prevented rising were coded as not being used. A review of Resident #160 ' s Care Area Assessment (CAA) dated 5/21/15 revealed she triggered for behaviors and falls. Resident #160 had short and long term memory problems and a few episodes of refusing medications over the last week and yelling at a nurse (The assessment date was 5/15/15.) She was admitted from the hospital to the facility after a fall from home for rehabilitation, strengthening and endurance. The facility proceeded to care plan due to behavioral symptoms and a history of falls. A review of the Progress Notes dated 6/14/15 revealed Resident # 160 was sitting at the Nurse ' s station in a Broda chair and was found on the floor in a sitting position. When staff asked the resident what happened she stated she tripped. For the intervention, staff placed Resident # 160 at the Nurse ' s station for close monitoring. A review of the Progress Notes dated 7/25/15 at 11:38 AM revealed Resident #160 ' s alarm was sounding and she was observed at her bedside on the floor in a sitting position. She was assessed for injuries and assisted back to a chair. For an intervention after her fall a therapy screening was initiated. On 9/2/15 at 8:41 AM the Rehab Manager stated Resident #160 was admitted to the facility for therapy and she started Physical Therapy on 5/12/15. Her therapy ended on 6/2/15 because	F 323	nurse managers. This review will include identifying any devices that could have been involved in the fall to ensure that they are appropriate for the patients care. These devices include but are not limited to bedrails, hi low mattresses or gerichairs. Devices should be reviewed to determine if the device was a hazard that could have contributed to the fall. A device/siderail evaluation should be completed to ensure that the if the device is a restraint that a restraint reduction plan is developed and implemented. This investigation should be document in the electronic health record and should include details regarding any resident, staff, family interviews that have been completed. Once the root cause of the fall is identified the clinical team will identify the appropriate prevention interventions for the patient and will implement such interventions. ¿ Witness statements should also be obtained and documented in the Quality Assurance Review. ¿ Upon completion of this review, interventions should be identified. Interventions may include alarms, medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning/strengthening exercises, increased supervision, one on one supervision, and other specifically related to the individual resident. Alarms should never be substituted for staff supervision or monitoring. ¿ Always implement 1:1 supervision for resident who are actively trying to get up unassisted. Also consider the devices	

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F 323	Continued From page 39 she was at her maximum potential. Resident #160 was able to ambulate with assistance. She could transfer to and from the bed to the wheelchair with minimal assistance. She was inconsistent and had cognition impairment and could not remember from day to day. She was assessed as being able to stand 2 minutes with contact guard assistance, but could not stand by herself. She always required some assistance. The Rehab Department did receive a referral in July 2015 and made attempts to pick her up for therapy but she was very aggressive and had cognitive impairment. The Rehab Department did not evaluate her regarding the side rails. A review of the Progress Notes dated 8/21/15 at 11:10 AM Nurse #6 was called to Resident #160's room by her roommate's family member. Documentation revealed the resident was found sitting on the floor beside her bed with her left arm caught in the side rail. The nurse documented that the family member stated that she and another visitor observed the resident moving about in her bed and "squirmed" until she had her feet off the side of the bed, and when her feet touched the floor, she slid because she did not have on her non-skid socks. The nurse further documented the family member stated Resident #160 was holding onto the side rail and when she slid to the floor her arm got caught in the side rail. The nurse assessed her for injuries and the resident was helped back into bed with her arm only being red and no break in the skin. On 9/1/15 at 5:12 PM the roommate's family member stated she was in Resident #160's room on the day she saw Resident #160 have her arm stuck in the side rail (8/21/15). She stated she visited every day and Resident #160 usually stuck her arm through the side rail. She stated on the day of the incident (8/21/15) the resident had her	F 323	that are being utilized for these patients. This is especially true if a patient is trying to get up unassisted out of a gerichair or over a bedrail or hi low mattress. ¿ If 1:1 supervision is initiated by a nurse/nursing assistant review the patient during daily clinical meeting to determine if 1:1 should continue and what other interventions may be initiated to minimize the risk. This review should also include the completion of a device/siderail evaluation form to ensure that restraints are identified. ¿ If a restraint is identified then the committee should create a restraint reduction plan. The restraint reduction plan should include reduction strategies and a time frame for the re-evaluation and completion of the process. On 9/3/15 the nurse managers began in-servicing all current nursing staff (RN, LPN, NA both full time and part time regarding the use of devices and side rails. The Director of Nursing will ensure that any employee who has not received this training by 9/3/15 will not be allowed to work until the training is completed. As of 9/3/15 approximately 50% of employees have received this training. This in-service included the following topics: ¿ Patients who are restless or trying to get out of bed should not be left unattended as this could result in a fall. ¿ In general when dealing with a patient who is agitated there are some basic steps you can follow to try and reduce the agitation. They include: listening,	

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F 323	Continued From page 40 body wrapped up in a sheet. Resident #160 was squirming and slid out of bed and she fell down on her knees. The family member stated as Resident #160 was observed falling out of bed she got her left arm stuck in the side rail. The family member stated the resident stated her knees were hurting and she went and got someone to help her. She stated she observed staff lifting her up and saying for them to be careful getting her arm out of the rail. She stated the facility just put the cushion over the side rail yesterday (8/31/15). On 9/1/15 at 3:25 PM Nurse #6 stated that she assessed Resident #160 on 8/21/15. Nurse #6 stated she was called into the resident's room by the roommate's family member and found Resident #160 sitting on the floor beside her bed with her left arm caught in the side rail. Nurse #6 stated the roommate's family member told her that Resident #160 had been moving around in her bed and had slipped out of the bed onto the floor. Nurse #6 further stated the roommate's family member told her that Resident #160 was holding onto the bed rail and she slid down onto the floor and her left arm slid into the side rail. Nurse #6 stated as staff were getting her off the floor they got her arm out of the side rail. Nurse #6 stated she assessed the resident and her left upper arm was a little red but she had no skin tears. A review of the incident report dated 8/21/15 revealed the facility ordered side rail pads. Non-skid socks were already in place. A review of the Progress Notes dated 8/31/15 at 11:49 AM revealed that half rail padding was added to Resident #160's side rails in the morning (8/31/15). During an interview on 9/2/15 at 9:41 AM, the MDS Coordinator stated she had been involved	F 323	providing reassurance, involve resident in activities, modify the environment, find outlets for the person¿s energy, check yourself to ensure your communication is calming and reassuring. ¿ Each patient is unique and interventions to minimize the risk of falling may range from offering favorite foods to playing music or a TV program that they may like. The patient¿s care plan will include interventions that should be used to try to calm the patient. The physician should also be notified so that medical interventions can be explored if the care plan interventions do not work or if the agitation is more severe than usual. If interventions listed in the care plan do not work and the physician cannot provide additional directions, then notify the DON or nurse manager on call. ¿ Anytime a patient is actively trying to get up unassisted or if they are trying to get out of a gerichair unassisted or throwing their legs over a side rail, one on one supervision must be implemented. Staffing should be reallocated to cover all patients until additional assistance can be called in to cover the one on one supervision. Your charge nurse should contact the administrator and DON immediately if a patient meets this criteria and to get assistance in coordinating the staffing needs. The administrators and DON phone numbers are listed at the nursing station. One on one supervision should be continued until the patient is reviewed by the Quality Assurance team and alternative safety interventions are identified and implemented. The QA team	

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F 323	Continued From page 41 with the Unit Manager, the Director of Nursing (DON), and the Administrator after the fall on 8/21/15. She stated they had decided to put a cushion over the side rail but there were no cushions available and they had to order a cushion that came in on 8/31/15. She stated they had nothing else in place to prevent her from getting her arm stuck through the side rails again. The MDS Coordinator further stated that she did not think the side rails were hazardous. During an observation on 8/31/15 at 2:33 PM Resident #160 was observed in her bed with padded side rails. The padding was observed with the ends of the padding extending 2 to 3 inches over the side rails. During an interview on 9/03/15 at 2:04 PM Resident #160's responsible party (RP) stated that the facility had called her about 2 weeks ago and told her that her roommate's family member had reported that Resident #160 had gotten tangled up in the covers, slid off the bed and got her left arm caught in the side rail. She stated staff had told her that she did not have any bruising. While talking the RP was observed lifting the sleeve from Resident #160's left arm and there was no bruising observed. The RP was then observed lifting the sleeve of her right arm. Resident #160's arm was observed with a dark purple bruise approximately 2 inches long and 1 inch wide. The RP stated her arm looked like it was bruised by the side rail. The RP asked Resident #160 how she got the bruise and she stated she got her arm caught in the side rail. During an interview on 9/3/15 at 2:06 PM Nurse #7 stated she was not aware of the resident having a bruise and asked Resident #160 how she had gotten the bruise and she stated she got her arm caught in the side rail. On 9/3/15 at 2:23 PM, with Nurse #7 and NA #12	F 323	should ensure that the complete a device evaluation or a siderail evaluation is completed. Also make sure to document the restlessness and any fall in the electronic health record. To assist in fall prevention make sure to include any devices (gerichair, bedrail. Hi low mattress or restraint) that was in use. This training was incorporated into the general orientation program and will be discussed during all general orientation programs that is completed started 9/2/15. Quality Assurance The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Monitor for monitoring fall interventions. This audit will review all incident reports that have occurred since the last review. The patient will be reviewed to ensure that if a device was involved that it has been evaluated to determine if it is a restraint and if there is a continued need for the device. Any newly identified falls interventions will also be reviewed to ensure that they are promptly implemented. This will be completed on all falls weekly times 4 weeks then on 10 falls monthly times 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	

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F 323	Continued From page 42 present, NA #12 stated that she was assigned to be Resident #160's NA on 9/3/15 and saw the bruise while she was bathing her at 7:30 AM. NA #12 stated she asked the resident how she thought it happened and Resident #160 told her she hurt it in the side rail. Nurse #7 stated the area looked like an older bruise that happened several days ago. She stated it did look like the bruise was from the side rail on her upper right arm. During an interview on 9/4/15 at 11:56 AM the Director of Nursing (DON) stated that she had been a part of the clinical meeting concerning Resident #160 ' s 8/21/15 fall. The DON stated she met with the Administrator, the Unit Manager and the MDS Coordinator. They discussed that the resident's arm did get caught in the side rail and they ordered padding to go over the rail. The DON stated that the roommate's family member told her that Resident #160 slid out of the bed using the side rail to hold on to and when her feet touched the floor she did not have on non-skid socks and slid getting her arm caught through the side rail. The DON stated she did not have any witness statements from the investigation and the incident report was what they used to discuss the fall. When the DON was asked if she was aware that when a resident got their arm caught through a side rail while exiting her bed, she was at risk for injury, the DON stated that side rails can be hazardous but she had assessed Resident #160 ' s side rails as an enabler to help her move in her bed. The DON stated she was still investigating why Resident #160 had the bruise on her right upper arm. The DON stated they did order the side rail cover to avoid her getting her arm stuck in the side rail again. She stated she was not aware that the padding did not come until 8/31/15 and would have expected her staff to let her know	F 323	Immediate Jeopardy Removal Date : 9/3/2015	

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F 323	Continued From page 43 if the padding was not available for that long. 2. Resident #78 was admitted to the facility on 10/16/12 and re-admitted on 11/10/14 with diagnoses including Senile Dementia, History of fall, History of Intracranial injury, Osteoarthritis, Anxiety, and aftercare for healing traumatic fracture of hip. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 8/20/15 identified Resident #78 as moderately cognitively impaired (Brief Interview for Mental Status (BIMS) of 9). Resident #78 had no behaviors. She required extensive two person assistance with bed mobility and transferring. She did not walk in room or hallways. Balance during transitions and walking was coded as 8 - as activity did not occur. She had no range of motion limitations. She did not use a cane/crutch/walker or wheelchair for mobility. She received an anti-anxiety and anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were not coded as being used. Review of the medical record revealed Resident #78 was 61 inches tall and weighed 92 pounds on 8/20/15. Review of most recent care plan dated 10/29/14, with a revised goal target date of 11/14/15, for use of side rails identified the Focus area as: ½ (half) side rails to both sides of the bed to enable	F 323		

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the resident to maintain as much independence with bed mobility as possible, with increased risk for complications. Interventions in meeting the goal of minimizing the risks for complications related to the use of side rails included, in part: periodically (at least quarterly) reassess for continued need for use of side rail and report to the nurse immediately if resident was noted between the rail and the bed.
During an interview with the MDS Nurse on 09/01/15 4:08 PM she stated Resident #78 does move around in bed and roll side to side. She did not roll on command but will move in the bed. She had a pressure alarm and fall mat alarm because of her history of falls.

During an interview with the MDS Nurse on 9/2/15 at 9:00 AM she stated that the care plan for side rails read to notify the nurse if the resident was between the rail and bed because the old beds use to have " a gap " between the rails and the bed and residents could get stuck. She stated now that note remains on the care plan as a precaution. She further stated the alarms are evaluated but Resident #78 still "moves a lot" so it is better if she has alarms. She stated Resident #78 will roll in bed and move from side to side. She also stated that while in the Geri chair she would throw her legs over the arms and this made her think Resident #78 could throw legs over the bed rail. The MDS Coordinator stated that Resident #78 would not know where to get up if she decided to get up, whether it be the top, middle or bottom of bed.
Review of the Side Rail Assessment dated 5/10/15 read the resident was unable to state her preference about the side rails. The side rails were ½ (half) in length on both sides of the bed. The resident has a history of falls. She had no

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history of falls from bed or attempts to get out of bed climbing over or around rails. She was mobile in the bed and did not turn side to side. She had difficulty with balance/trunk control and had a decreased safety awareness. The side rail decision was to continue with the current side rails.
Review of the Physician Communication note dated 6/19/15 listed a concern that Resident #78 was discontinued off Zoloft (anti-depressant medication) on 5/10/15. Resident #78 was now real agitated and thought she could walk again and was having spells of yelling at staff and crying out for no reason and had increased nervousness.
During an interview with Nurse #3 on 9/2/15 at 9:25 AM she stated that on 6/19/15 the resident was fighting and attempting to get out of bed so she notified the Physician. She stated Resident #78 was trying to get out of bed by scooting to bottom of the bed to exit.
During an observation on 8/31/15 at 2:30 PM Resident #78 was noted to be in her bed with ½ (half) side rails in the up position on both sides of the bed. The rails had a top and bottom rail with an approximate 4 inch gap between the bottom and top rail. There was approximately 16 " from top of bed to the start of side rail which was then approximately 2 foot long. The mattress was a high-low mattress with the upper and lower portion of the mattress high and a portion in the middle of the mattress lower. The side rail was observed to be placed next to the low area of the hi-low mattress. There was an alarming fall mat on the floor next to the bed. The resident was observed to have her left leg over the side rail and her right leg through the top portion of the side rail lying horizontal in her bed with her head in the direction of the wall. The bed was pushed

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F 323	Continued From page 46 against the wall. She was alert but not oriented. During an observation on 8/31/15 at 5:12 PM Resident #78 was asleep in her bed with legs observed in bed. The half side rails were in the up position on both sides and an alarming fall mat was on floor. During an interview with Nurse #5 on 9/1/15 at 3:48 PM she stated that Resident #78 could turn from side to side in bed, was not supposed to get up on her own and had an alarming fall mat. She continued by stating that once in a while Resident #78 would hang her legs over the bed but there were alarms if she got up. During an interview on 09/01/2015 3:51 PM with Nursing Assistant #4 she stated that the resident can move around in the bed and turn side to side. She had alarms on the bed and a fall mat because of a previous fall and fractured hip. She stated Resident #78 had no range of motion limitations. She stated she thought the facility left the alarms on because Resident #78 used to get out of bed unassisted. During an observation on 9/1/15 at 4:52 PM Resident #78 was observed with her right leg out of the bed wedged between the hi-low mattress and the side rail with her foot dangling towards the fall mat. Nurse #5 was made aware and entered the resident ' s room. During an interview on 9/1/15 at 4:55 PM with Nurse #5, upon entering Resident #78s room, she stated " This is why we keep the alarms because she tries to get out of bed. " Nurse #5 then took the resident ' s leg and stated to the resident, " let ' s get your leg up here and turn you back in bed. " Resident #78 was observed on 9/3/15 at 2:00 PM. She had a low bed, high-low mattress and bed and fall mat alarms in place. The side rails had been removed.	F 323		

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F 323	Continued From page 47 During an interview with the DON on 9/4/15 at 11:56 AM she stated that behaviors such as putting legs or arm through side rails are hazardous; but she was unaware of these residents having these behaviors or she would have acted on the issue immediately. The Administrator was notified of the Immediate Jeopardy on 9/2/15 at 3:06 PM. The Immediate Jeopardy was removed on 9/4/15 at 3:30 PM based on the Credible Action Plan. Interventions listed on the plan included: The Administrator was notified of the Immediate Jeopardy on 9/2/15 at 3:06 PM. The Immediate Jeopardy was removed on 9/4/15 at 3:30 PM. Interventions listed on the plan included: What measures the facility put into place for the resident affected: For Resident #160 on 8/31/15 the padding was placed on the side rails. On 9/3/15 the side rails were removed from the bed as a results of the side rail assessment completed on 9/3/15 by the care plan team. For Resident #78 on 9/3/15 the care plan team evaluated the use of the hi-low mattress. The team decided to continue the use of the hi-low mattress and reevaluate weekly for a maximum of 30 days since the side rail reduction has also occurred. The care plan team also completed a device evaluation related to the side rail and discontinued its use on 9/3/15 as a result of the evaluation. WHAT MEASURES WERE PUT IN PLACE FOR RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED? All residents have the potential to be affected by this alleged deficient practice. On 9/2-3/15 the nurse reviewed all current patients who have had a fall in the last 12 months. To accomplish this the nurse managers printed a list of patients that	F 323		

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had a fall incident report. The incident report was then reviewed by the nurse manager to identify the reason and/or contributing factors for the fall. This included reviewing falls for any indication that the bed rail contributed to the accident. Interventions for the falls was then reviewed by the nurse manager to ensure that the interventions were appropriate. Interventions may include alarms but also included medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning/strengthening exercises, increased supervision, one on one supervision, and other specifically related to the individual resident. Any incident involving a bed rail was also reviewed to ensure that the bed rail had been discontinued if no longer required by the patient. Any resident who was identified that did not have a falls prevention intervention or whose fall prevention intervention was not related to the specific fall was reviewed by the care planning team (nursing, social, activities and therapy) on 9/3/15 and interventions were identified and implemented as appropriate. Interventions may include alarms but also included medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning/strengthening exercises, increased supervision, one on one supervision, and other specifically related to the individual resident.

WHAT SYSTEMS WERE PUT IN PLACE TO PREVENT THE DEFICIENT PRACTICE FROM REOCCURRING?

On 9/3/15 the QA Nurse Consultant, in serviced all nurse ' s managers (unit managers, MDS, SDC and DON) on restraints.

· Daily during clinical meeting all incident reports will be reviewed by the nurse managers. This review will include identifying any

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F 323	Continued From page 49 devices that could have been involved in the fall to ensure that they are appropriate for the patients care. These devices include but are not limited to bedrails, hi low mattresses or Geri chairs. Devices should be reviewed to determine if the device was a hazard that could have contributed to the fall. A device/side rail evaluation should be completed to ensure that if the device is a restraint that a restraint reduction plan is developed and implemented. This investigation should be document in the electronic health record and should include details regarding any resident, staff, family interviews that have been completed. Once the root cause of the fall is identified the clinical team will identify the appropriate prevention interventions for the patient and will implement such interventions. · Witness statements should also be obtained and documented in the Quality Assurance Review. · Upon completion of this review, interventions should be identified. Interventions may include alarms, medication evaluations, pharmacy evaluations, therapy evaluations for alternative positioning/strengthening exercises, increased supervision, one on one supervision, and other specifically related to the individual resident. Alarms should never be substituted for staff supervision or monitoring. · Always implement 1:1 supervision for resident who are actively trying to get up unassisted. Also consider the devices that are being utilized for these patients. This is especially true if a patient is trying to get up unassisted out of a Geri chair or over a bedrail or high-low mattress. · If 1:1 supervision is initiated by a nurse/nursing assistant review the patient during	F 323		

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daily clinical meeting to determine if 1:1 should continue and what other interventions may be initiated to minimize the risk. This review should also include the completion of a device/side rail evaluation form to ensure that restraints are identified.

· If a restraint is identified then the committee should create a restraint reduction plan. The restraint reduction plan should include reduction strategies and a time frame for the re-evaluation and completion of the process.

On 9/3/15 the nurse managers began in-servicing all current nursing staff (RN, LPN, NA both full time and part time regarding the use of devices and side rails. The Director of Nursing will ensure that any employee who has not received this training by 9/3/15 will not be allowed to work until the training is completed. As of 9/3/15 approximately 50% of employees have received this training. This in-service included the following topics:

Patients who are restless or trying to get out of bed should not be left unattended as this could result in a fall.

In general when dealing with a patient who is agitated there are some basic steps you can follow to try and reduce the agitation. They include: listening, providing reassurance, involve resident in activities, modify the environment, find outlets for the person ' s energy, and check yourself to ensure your communication is calming and reassuring.

Each patient is unique and interventions to minimize the risk of falling may range from offering favorite foods to playing music or a TV program that they may like. The patient ' s care plan will include interventions that should be used to try to calm the patient. The physician should also be notified so that medical interventions can

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be explored if the care plan interventions do not work or if the agitation is more severe than usual. If interventions listed in the care plan do not work and the physician cannot provide additional directions, then notify the DON or nurse manager on call.
Anytime a patient is actively trying to get up unassisted or if they are trying to get out of a Geri chair unassisted or throwing their legs over a side rail, one on one supervision must be implemented. Staffing should be reallocated to cover all patients until additional assistance can be called in to cover the one on one supervision. Your charge nurse should contact the administrator and DON immediately if a patient meets this criteria and to get assistance in coordinating the staffing needs. The administrators and DON phone numbers are listed at the nursing station. One on one supervision should be continued until the patient is reviewed by the Quality Assurance team and alternative safety interventions are identified and implemented. The QA team should ensure that the complete a device evaluation or a side rail evaluation is completed. Also make sure to document the restlessness and any fall in the electronic health record. To assist in fall prevention make sure to include any devices (Geri chair, bedrail. hi-low mattress or restraint) that was in use.
The Credible Allegation was verified by:
1. Record review of In-Service Education content and sign in sheets.
2. Interviews on 9/4/15 at 1:20 PM through 9/4/15 at 3:30 PM with Nurses, Unit Managers and Nursing Assistants on all halls for both first and second shift confirming recent in-service.
3. For Resident #160, the side rails were removed from the bed as a results of the side rail

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F 323	Continued From page 52 assessment completed on 9/3/15 by the care plan team. Resident #160 was observed without her side rails 4. For Resident #78 on 9/3/15 the care plan team evaluated the use of the hi-low mattress. The team decided to continue the use of the hi-low mattress and reevaluate weekly for a maximum of 30 days since the side rail reduction has also occurred. The care plan team also completed a device evaluation related to the side rail and discontinued its use on 9/3/15 as a result of the evaluation. 5. A review of the list of residents with side rail evaluation and that the evaluation was implemented. 3. Resident #78 was admitted to the facility on 10/16/12 and re-admitted on 11/10/14 with diagnoses including Senile Dementia, History of fall, History of Intracranial injury, Osteoarthritis, Anxiety, and aftercare for healing traumatic fracture of hip. Review of the most recent annual Minimum Data Set (MDS) Assessment dated 10/1/14 identified Resident #78 as being cognitively impaired (BIMS of 4). Resident #78 had no behaviors. She required the assistance of two persons with bed mobility and transferring. She did not walk in her room or corridor. Resident #78 had no range of motion limitations. She used no mobility devices (cane/crutch/walker or wheelchair). She was not steady, only able to stabilize with staff assistance while moving from seated to standing position and surface-to-surface transferring (between bed and chair or wheelchair) and balance during walking, turning around and moving on and off the toilet -this activity did not occur. Resident #78 had had one fall with no injury. She weighed 106 pounds. She received an anti-anxiety and	F 323		

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anti-depressant medications seven days a week. Restraints (bed rails, trunk restraints, limb restraints or chair that prevents rising) were coded as not being used.
Review of the Care Area Assessment (CAAs) Summary dated 10/1/14 triggered in the areas of Cognitive Loss/Dementia, Delirium, Falls and Psychotropic Drug Use.
Review of the CAA revealed falls was triggered related to balance problems during transitioning, having at least one fall since admission and she received antidepressants and antianxiety medications seven days per week. Care plan considerations included: (Resident #78) remains at an increased risk for falls due to frequent attempts to get out of bed unassisted, along with increased confusion at times. The staff were to monitor resident for any attempts to get up unassisted or any other factors that may have contributed to a fall and intervene as needed to prevent falls from occurring.
Review of the revised care plan dated 10/6/14 for falls identified the Focus area as Resident #78 being at risk for falls related to Confusion, Psychoactive drug use, history of falls and frequent attempts to get up unassisted. Interventions in meeting the goal of minimizing the risk of falls included, in part: repeated interventions of keeping the resident at the nursing station for supervision, re-educating staff on fall precautions and the need for the resident to be in view of staff while up in Geri chair, educating staff to keep resident at nurses station when in Geri chair and to putting Resident #78 in bed if in her room, keeping the bed in the lowest position, having the personal alarm in place, the chair alarm in place, the floor mat alarm in place and the bed alarm in place while in bed.
During an interview with the Rehabilitation

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F 323	Continued From page 54 Manager on 9/3/15 at 10:00 AM she stated that Resident #78 was screened on 9/25/14 because the resident appeared agitated and was trying to get up out of her Geri chair. She stated the recommendation was that Resident #78 would be supervised while in her Geri chair. She further stated that Resident #78 was seen on 10/6/14 for Geri chair positioning after a fall from the chair. She stated that on 10/6/14 it was noted that Resident #78 had cognitive impairment and attemptedto get out of the Geri chair and supervision was required. Review of the Fall report dated 10/28/14 revealed the nurse heard Resident #78 ' s personal alarm and found her sitting upright on her buttocks on the floor in her room approximately six inches from the chair. Resident #78 only stated " I can ' t get up, I can ' t get up. " She was assessed by Nurse #1 for injuries and assisted back to bed. The intervention listed was to re-educate the staff to keep the resident in view when she was in her Geri chair. Review of the Nursing Progress Note dated 10/28/14 documented that Resident #78 was found sitting on the floor of her room. The personal alarm was sounding. She was unable to state what happened, only saying, " I can ' t get up " over and over again. No injuries were noted and the resident was assisted to bed. During an interview with the Director of Nursing (DON) on 9/2/15 at 9:10 AM she stated that the fall report of 10/28/14 read to re-educate the staff on placing the resident in view because Resident #78 gets up unassisted and the staff need to be reminded to place her in view. During an interview with Nursing Assistant #1 on 9/3/15 at 3:05 PM, who worked with Resident #78 on 10/28/14 during the 3 PM - 11 PM shift, she stated that she put Resident #78 to bed	F 323		

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sometime after dinner. She remembered that the resident was restless. She stated she laid Resident #78 down and left the room to check on another resident. She stated when she came back down the hall she heard the alarm going off and went into the resident ' s room and Resident #78 was sitting up on the side of the bed like she was going to get up. NA #1 told the resident it was time to go to sleep. NA #1 stated that it was clear to her Resident #78 was not going to lay down so she put her back into the Geri chair. She stated she set the alarms and leaned the chair back with her feet up. She further stated she always put the chair in a reclining position and elevated the feet.

During an interview with Nurse #1 on 9/3/15 at 3:30 PM, she stated that on the evening of 10/28/14 she was passing medications when she heard Resident #78 talking and her alarm sounding. She entered the room to find the resident sitting on the floor. She stated the resident had been in her Geri-chair. She stated the resident was not complaining of pain and she assessed the resident and everything looked fine. She had another nurse (Nurse #2) help return the resident to her bed. She stated the resident was picked up and placed in bed.

Review of the Nursing Progress Note dated 10/29/14 revealed Resident #78 was sitting in the Geri chair in her room and was complaining of pain in the left leg. She was given Tylenol and the physician was contacted to obtain an order for an x-ray at approximately 3:15PM.

During an interview with the DON on 9/4/15 at 11:56 AM she stated she was unaware who decided on the use of a Geri chair for Resident #78. She stated when the resident was admitted to the facility she shuffled her feet and the facility tried grip slips and this did not work. She

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F 323	Continued From page 56 continued to state she was unaware that the resident was throwing her legs over the Geri chair. Review of the Nursing Note dated 11/4/14 documented the nurse entered the resident ' s room for the morning medication pass at 7:40 AM and the resident started to complain of left leg and hip pain and yell out in severe pain. The left thigh was swollen and the left leg was shorter than the right leg. The physician was notified and an order received to send the resident to the emergency room for evaluation. Review of the Nursing Progress Note dated 11/4/14 documented the resident was admitted to the hospital with a left Proximal Femur fracture. Review of the Hospital x-ray report dated 11/4/14 documented a fracture proximal left femur. Review of the Hospital physical exam dated 11/4/14 documented the chief complaint as hip pain. The left leg was short and rotated. She had decreased range of motion of the left lower extremity secondary to the fracture. She had some bruising on the legs. Review of the Hospital discharge summary dated 11/10/14 listed the discharge diagnoses as left hip fracture, status post ORIF (open reduction internal fixation).	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		10/2/15

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F 441	Continued From page 57 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to ensure the spread of infection by placing soiled linens directly on a bedside table after providing incontinence care, wearing visibly soiled gloves while removing wipes from a dresser and turning off a call light and placing a lunch tray on an unwiped bedside table for 1 of 1 sampled residents (Resident #45)	F 441	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	

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F 441	Continued From page 58 whose personal care was observed. Findings included: During an observation of incontinent care for Resident #45 on 8/31/15 at 11:25 AM, NA #11 was observed to undo the brief. Stool was observed between thighs, vagina, and when rolled over on buttocks. The NA had gloves on and was using a wet washcloth to clean the resident. There was so much stool she stated she needed wipes. NA #11 then walked over to the dresser and with visibly soiled gloves opened the top drawer of the dresser and removed the box of wipes. Stool was observed on her gloves. She placed the box on the bed. She then began cleaning the resident with the wipes and using the wipes to clean her gloves trying to remove stool from her gloves. A nurse knocked on the door and came in because the call light was on. NA #11 leaned back with her visibly soiled gloves on and pushed the call light off. Stool was observed on the gloved hand. NA #11 began using washcloths to remove the stool from the resident and placed the visibly soiled washcloths directly on the bedside table. NA #11 was observed to complete incontinent care wiping from front to back. She changed her gloves after cleaning the front side of the resident and re-gloved. She then rolled the resident to her left side and cleaned the back of the resident. Again, stool soiled washcloths were placed directly on top of the bedside table. NA #11 kept wiping her gloves off with wipes to remove stool. Upon completion of incontinent care, the resident was turned back to her back and the new brief fastened. The resident was then dressed by NA #11 while she wore the gloves in which she provided incontinent care. After dressing the resident the NA removed the	F 441	constitutes the facility¿s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 441 Corrective Action for Affected Residents Resident # 45, the involved CNA was reeducated on 09/16/15 by the Staff Development Coordinator on infection prevention strategies when providing perineal care to a resident. Corrective Action for Potentially Affected Residents All residents have the potential to be affected. On 09/21/15, the QA Nurse Consultant completed an audit of the facility on 09/21/15, 09/22/15, and 09/23/15. The audit reviewed staff practices for proper hand washing techniques; glove use; soiled gloves removed and disposed properly before touching other equipment or patient surroundings; observed for proper precautions used for the disposal of soiled linens; and if linens and laundry are handled in a manner that prevents the spread of infection. No negative findings were noted as a result of this audit. Systematic Changes On 09/24/15 the Staff Development Coordinator in-servicing all current nursing staff (CNA, RN, LPN, both full time and part time. In-service topics included: Glove use, change gloves during use if torn and when heavily soiled (even during use on the same patient). After use on each patient discard in	

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F 441	Continued From page 59 soiled washcloths from bedside table by placing them into a plastic bag. NA #11 then carried the plastic bag to the soiled utility room and placed in the bin and washed her hands. She then returned to hall and grabbed the lunch tray for Resident #45 from the cart and placed the lunch tray on bedside table. She was not observed to clean or wipe the bedside table prior to placing the tray on top. During an interview with Nursing Assistant #11 on 8/31/15 at 12:11 PM she stated that she should have changed her gloves after providing incontinent care when the gloves had stool on them instead of trying to clean off gloves and she was supposed to place soiled linens in a bag and not on the bedside table. She stated she should have wiped the bedside table before placing the lunch tray on top. During an interview with the Staff Development Coordinator on 9/3/15 at 10:15 AM she stated it is the policy to change your gloves once they are visibly soiled. The NA should not have used soiled gloves to open the dresser drawer or turn off the call light. The soiled linens are to be placed in a bag and then one glove removed before going down the hall to the soiled linen room. One hand is glove free to open doors. Hands are washed in the soiled linen room. She stated the bedside table should have been cleaned prior to setting the lunch tray on top.	F 441	appropriate receptacle. Never wash, WIPE, or reuse disposable gloves. Contaminated linen should never be placed on the resident¿s bed side table, over bed table or any other equipment in the room. It must be bagged when removed from the resident bed. This is also true for disposable briefs and wipes. If equipment contamination occurs, the area should be wiped down using disinfectant wipes. You should perform hand hygiene immediately after removing gloves. If your hands become visibly contaminated wash your hands thoroughly with soap and warm water or, if hands are not visibly contaminated, use an alcohol-based hand rub. Any in-house staff member who did not receive in-service training by 10/02/15 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all nurses and CNA¿s and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Staff Development Coordinator will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Infection Control Practices. The monitoring will include observing staff practices for glove use and disposal, linen removal and disposal, and hand hygiene by observing resident care on 8 residents weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly	

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F 441	Continued From page 60	F 441	Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews the facility failed to provide full visual privacy for residents whose privacy curtains were not wide enough for 3 of 5 halls. The findings included: 1. On 8/31/15 at 3:26 PM in Room # 311 Bed # 2 ' s closed privacy curtain was observed with a 3 foot gap from the end of the curtain to the wall. The resident in Bed # 1 stated that the curtain did not provide her with full visual privacy. On 9/4/15 at 11:35 AM in Room # 311 Bed # 2 ' s closed privacy curtain was observed with a 3 foot gap from the end of the curtain to the wall.	F 460	F 460 Corrective Action for Resident Affected: For the affected residents in the following rooms: 311 bed 2, 511 bed 1 and 2, 509 bed 1and 2, 508 bed 1 and 2, 507 bed 1 and 2, 505 bed 1 and 2, 503 bed 1 and 2, 506 bed 1 and 2, 312 bed 2, 804 bed 1and 2, 813 1 and 2, and 815 1 and 2 the residents privacy curtains were replaced with appropriate length privacy curtains providing full privacy when pulled. This was completed by the maintenance	10/2/15

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F 460	Continued From page 61 2. During an observation of Room # 511 on 9/01/15 at 3:15 PM, the privacy curtain did not provide full visual privacy for bed #1 and bed # 2. The closed privacy curtain for Bed # 1 was observed with a 1 foot gap at the foot of the bed to the end of privacy curtain. Bed # 2 was observed with a 2 foot gap from the end of the closed privacy curtain to the wall. On 9/2/15 at 2:07 PM in Room # 511 Bed # 1 ' s the closed privacy curtain was observed to not provide full visual privacy for bed #1 and bed # 2. Bed # 1 ' s closed privacy curtain was observed with a 1 foot gap at the foot of the bed to the end of privacy curtain. Bed # 2 ' s closed privacy curtain was observed with a 2 foot gap from the end of the privacy curtain to the wall. On 9/3/15 at 9:37 AM in Room # 511, the privacy curtain did not full visual privacy for Bed #1 and Bed # 2. Bed # 1 ' s closed privacy curtain was observed with a 1 foot gap at the foot of the bed to the end of privacy curtain. Bed # 2 ' s closed privacy curtain was observed with a 2 foot gap from the end of the privacy curtain to the wall. 3. On 9/1/15 at 3:21 PM in Room # 509 Bed #1 ' s was observed with the privacy curtain closed and 1 foot gap was observed from the foot of the bed to the end of the curtain. The closed privacy curtain for Bed # 2 in room # 509 was observed to not provide full visual privacy for 16 feet from the end of the privacy curtain to the wall. On 9/2/15 at 2:06 PM in Room # 509 Bed #1 ' s closed privacy curtain was observed with a 1 foot gap from the foot of the bed to the end of the curtain. Bed # 2 ' s closed privacy curtain was observed to not provide full visual privacy for 16 feet from the end of the privacy curtain to the wall. On 9/3/15 at 9:36 AM in Room # 509 Bed #1 ' s	F 460	director and housekeeping director on September 4, 2015. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected. All resident rooms were audited by the Maintenance Director to determine if curtains in other rooms provided full privacy. Forty six rooms were identified as needing wider privacy curtains. On September 22, 2015 an order was placed with Phoenix Textile Corporation to replace any curtains that do not provide full privacy. Until these privacy curtains arrive, privacy curtains have been obtained from other facilities to minimize the gaps. Systemic Changes On September 23, 2015, the Administrator in-serviced the Housekeeping and Maintenance Directors. The in-service content included: Privacy curtains must be of appropriate width to provide complete privacy for both residents in the room. There cannot be any gaps exposing the resident. On September 24, 2015, an in-service was held with FT, PT and PRN CNA¿s and Nurses. The Staff Development Coordinator covered the following topic: Privacy curtains must be pulled when providing care to the resident. If a privacy curtain does not adequately provide full privacy, then notify Maintenance.	

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F 460	Continued From page 62 closed privacy curtain was observed with a 1 foot gap from the foot of the bed to the end of the curtain. Bed # 2 ' s closed privacy curtain did not provide full visual privacy for 16 feet from the end of the privacy curtain to the wall. 4. On 9/1/15 at 3:30 PM Room # 508 Bed #1 ' s closed privacy curtain was observed with a 1 foot gap at the end of the curtain. Also in Room # 508 Bed #2 ' s closed privacy curtain was observed to not provide full visual privacy for 2 feet from the end of the privacy curtain to the wall. On 9/2/15 at 2: 05 PM in Room # 508 Bed #1 ' s closed privacy curtain was observed with a 1 foot gap from the end of the privacy curtain to the wall. Bed #2 ' s closed privacy curtain was observed to not provide full visual privacy for 2 feet from the end of the privacy curtain to the wall. On 9/3/15 at 9:35 AM in Room # 508 Bed #1 ' s closed privacy curtain was observed with a 1 foot gap at the end of the curtain. Bed 2 ' s closed privacy curtain did not provide full visual privacy for 2 feet from the end of the privacy curtain to the wall. 5. On 9/1/15 at 3:33 PM in Room # 507 Bed #2 ' s closed privacy curtain was observed with a 2 foot gap from the end of the privacy curtain to the wall. On 9/2/15 at 2:03 PM in Room # 507 Bed #2 ' s closed privacy curtain was observed with a 2 foot gap from the end of the privacy curtain to the wall. On 9/3/15 at 9:35 AM PM in Room # 507 Bed #2 ' s closed privacy curtain was observed with a 2 foot gap from the end of the privacy curtain to the wall. 6. On 9/1/15 at 3:35 PM in Room # 505 Bed # 1 ' s privacy curtain was observed with a 2 foot gap from the foot of the bed to the end of the curtain.	F 460	Any in-house staff member who did not receive in-service training by October 2, 2015 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all housekeepers, maintenance employees, nurses and CNA¿s and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Administrator or designee will monitor this issue using the Survey Quality Assurance Monitor for monitoring privacy curtains. This tool will audit 10 rooms for privacy curtain issues such as not providing full privacy when pulled. This will be completed weekly times four weeks then monthly times three months or until resolved by QOL/QA committee. See Attachment A. Reports will be given to the weekly QOL/QA committee and corrective action initiated as appropriate. The QA/QOL Committee consist of the Administrator, Director of Nursing, Nurse Managers, Social Workers and Dietary Manager.	

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F 460	Continued From page 63 Observations of Bed # 2 ' s closed privacy curtain revealed the end of the privacy curtain was observed with a 3 foot gap from the end of the curtain to the wall. On 9/2/15 at 2:01 PM in Room # 505 Bed # 1 ' s closed privacy curtain was observed with a 2 foot gap from the foot of the bed to the end of the curtain. Observations of Bed # 2 ' s closed privacy curtain revealed a 3 foot gap from the end of the curtain to the wall. On 9/3/15 at 9:34 AM in Room # 505 Bed # 1 ' s closed privacy curtain was observed with a 2 foot gap from the foot of the bed to the end of the curtain. Bed # 2 ' s closed privacy curtain was observed with a 3 foot gap from the end of the curtain to the wall. 7. On 9/1/15 at 3:38 PM in Room # 503 Bed # 1 was observed with the privacy curtain closed and a 4 foot gap from the foot of the bed to the end of the curtain. Observations of the closed privacy curtain for Bed # 2 in room # 503 revealed a 4 foot gap from the end of the curtain to the wall. On 9/3/15 at 9:26 AM in Room # 503 Bed # 1 ' s closed privacy curtain was observed with a 4 foot gap from the foot of the bed to the end of the curtain. Bed # 2 ' s closed privacy curtain was observed with a 4 foot gap from the end of the curtain to the wall. 8. On 9/1/15 at 3:42 PM in Room # 506 Bed # 1 ' s privacy curtain was observed closed with a 2 foot gap from the end of the curtain to the wall. Observations of the closed privacy curtain for Bed # 2 closed privacy curtain revealed a 5 foot gap from the end of the curtain to the wall.	F 460		

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F 460	Continued From page 64 On 9/2/15 at 2:04 PM in Room # 506 Bed # 1 ' s closed privacy curtain was observed with a 2 foot gap from the end of the curtain to the wall. Bed # 2 ' s privacy curtain was observed with a 5 foot gap from the end of the curtain to the wall. On 9/3/15 at 9:25 AM PM Room # 506 Bed # 1 ' s closed privacy curtain was observed with a 2 foot gap from the end of the curtain to the wall. Bed # 2 ' s closed privacy curtain was observed with a 5 foot gap from the end of the curtain to the wall. 9. On 9/3/15 at 9:41 AM in Room # 312 Bed # 2 ' s closed privacy curtain was observed with a 4 foot gap from the end of the curtain to the wall. On 9/4/15 at 11:34 AM in Room # 312 Bed # 2 ' s closed privacy curtain was observed with a 4 foot gap from the end of the curtain to the wall. During an interview on 09/03/2015 at 10:19 AM the Housekeeping Supervisor revealed housekeeping was responsible for the privacy curtains. She acknowledged that most of the privacy curtains were too short. The Housekeeping Supervisor said housekeeping staff was responsible for hanging the privacy curtains that they had enough privacy curtains. She stated the floor technician in housekeeping was responsible for ensuring the curtains were clean and wide enough. She added that if the privacy curtains were dirty the curtains were taken down and washed. The Housekeeping Supervisor revealed the Nursing Assistants would tell housekeeping staff if the privacy curtains needed to be taken down and washed. She also stated if she observed that the curtains needed to be changed, she would take them down and	F 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 09/04/2015

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F 460	Continued From page 65	F 460		

change them. The Housekeeping Supervisor revealed her
expectation was for Nursing Assistants to tell her staff if the privacy curtains were not clean, to inform the floor technician, and if the floor technician was gone, to inform her and she would change the privacy curtains. The Housekeeping Supervisor stated she would have maintenance measure the privacy curtains.

During an interview on 9/4/15 at 10:16 AM the Administrator stated that she would expect privacy curtains to provide full visual privacy for all residents.

On 9/4/15 at 10:46 AM during an observation with the Administrator the closed privacy curtains in Rooms # 503, 505, 506, 507, 508, 509 and 511 curtains were again observed to not provide full visual privacy when pulled around resident beds.

10. During an observation on 9/01/2015 at 3:48 PM in room 804 , the privacy curtain for bed A was 12 inches too short from the end of the privacy curtain to the wall adjacent to the head of bed A. The privacy curtain between bed A and bed B was short by 4 feet from the end of the privacy curtain to the wall adjacent to the head of bed B.

During an observation on 9/2/15 at 2:57 PM the privacy curtains for room 804 bed A and bed B remained the same.

During an observation on 9/3/15 at 10:00 AM in room 804 the privacy curtains for bed A and bed B remained the same.

11. During an observation on 9/01/2015 at 3:51

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F 460	Continued From page 66 PM in room 813, the privacy curtain between bed A and bed B was 4 feet short from the end of the privacy curtain to the wall adjacent to the head of bed B and was also missing two privacy curtain hooks. During an observation on 9/2/15 at 2:54 PM in room 813, the privacy curtain between bed A and bed B remained the same. During an observation on 9/3/15 at 10:00 AM for room 813, the privacy curtain between bed A and bed B remained the same. 12. During an observation on 09/01/2015 at 3:52 PM in room 815, the privacy curtain for bed A was missing 6 hooks and was 24 inches short from the end of the privacy curtain to the wall adjacent to the head of bed B. The privacy curtain between Bed A and Bed B was short by 2 feet, from the end of the privacy curtain to the wall. During an observation on 9/2/15 at 2:56 PM in room 815, the privacy curtains for bed A and bed B remained the same. During an observation on 9/3/15 at 10:01 AM in room 815, the privacy curtains for Bed A and bed B remained the same. During an interview on 09/03/2015 at 10:19 AM the Housekeeping Supervisor revealed housekeeping was responsible for the privacy curtains. She acknowledged that most of the privacy curtains were too short. The Housekeeping Supervisor said housekeeping staff was responsible for hanging the privacy curtains that they had enough privacy curtains. She stated the floor technician in housekeeping	F 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 460	Continued From page 67 was responsible for ensuring the curtains were clean and wide enough. She added that if the privacy curtains were dirty the curtains were taken down and washed. The Housekeeping Supervisor revealed the Nursing Assistants would tell housekeeping staff if the privacy curtains needed to be taken down and washed. She also stated if she observed that the curtains needed to be changed, she would take them down and change them. The Housekeeping Supervisor revealed her expectation was for Nursing Assistants to tell her staff if the privacy curtains were not clean, to inform the floor technician, and if the floor technician was gone, to inform her and she would change the privacy curtains. The Housekeeping Supervisor stated she would have maintenance measure the privacy curtains. On 9/03/2015 at 10:46 AM, the Housekeeping Supervisor observed the rooms on the 800 hall where the privacy curtains needed to be changed. During an interview on 9/4/15 at 12:50 PM, the Administrator revealed staff were working to change curtains to provide full visual privacy.	F 460		