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	345391	A. BUILDING _____ B. WING _____	C 10/02/2015

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F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(h) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with staff, the facility failed to secure Resident #2 in a safe position during a bed bath to prevent a fall from the bed to the floor. As a result, the resident sustained a left frontal forehead hematoma, bruises to both cheeks, laceration to the head, and bilateral upper extremity skin tears. This was evident for 1 of 3 residents (Resident #2) who were reviewed for falls. Findings included: Record review for Resident #2 revealed the resident was admitted to the facility with Heart Failure, General Muscle Weakness, Late Effect Cerebrovascular Disease, Atrial Fibrillation, Neurologic Neglect Syndrome, Non-Alzheimer ' s Dementia, and Hypothyroidism. Review of the Medication Administration Record of September 2015 indicated Resident #2 had physician ' s orders for an anticoagulant. The orders read: Xarelto 15 milligrams tablet, give one by mouth everyday with supper.	F 323	Past noncompliance: no plan of correction required.	10/19/15

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

Electronically Signed | 10/19/2015

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Review of the Annual Minimum Data Set (MDS) Assessment dated 04/24/15 and the Quarterly MDS dated 07/16/15 for Resident #2 indicated the resident required extensive assistance with two plus person physical assistance for bed mobility, one person physical assistance for bathing and transfers. For balance the resident was not steady, and only able to stabilize with staff assistance for surface to surface transfers. The resident had a Brief Interview for Mental Status Score (BIMS) of 3 (severe cognitive impairment), 2 or more falls since admission, and always incontinent of bowel and bladder.

The initial care plans which were not dated read: Problem/Need #1 I required staff assistance for all ADLS (Activities of Daily Living). The Approaches read: I prefer a bed bath. Give me verbal cues to help prompt me. Allow me rest breaks between tasks. One person to assist me with bathing. I am frequently incontinent of urine. Approaches included: Initiate scheduled toileting plan based on my assessment. Provide me with incontinent pads. Assist me with perineal cleansing as needed. Problem/Need #2, I have a history of falling. Approaches: Assist me with one staff member for all ambulation. Monitor for changes in my condition that may warrant increased supervision/assistance and notify the physician. Problem/Need #3 I am at risk for bleeding due to anticoagulant therapy related to atrial fibrillation. Approaches included: Administer my anticoagulant as ordered by my physician. Coordinate my laboratory work as ordered.

Review of the Resident Incident Report of 09/18/15 indicated Resident #2 had a fall with head injury at 10:11 AM. The report read: Type of

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injury: Skin tear, hematoma, fracture. Location: Resident room. Equipment: Electric bed. Narrative of the incident and description of injuries: NA (Nursing Assistant) reports that the resident was turned to her left side and the NA was cleaning her up, and had just completed a bed bath. She (NA) took her hands off the resident to reach for items and the resident rolled off the side of the bed and fell to the floor. The resident has a forehead hematoma and bilateral upper extremity skin tears. The Director of Nurses applied a pressure wrap to the head and kerlix wrap to bilateral arms to stop bleeding. Immediate Action Taken: Emergency Services Transported to the hospital to evaluate for other injuries status post fall.

Review of the facility investigation of 09/18/15 read: The NA (NA#1) was giving the resident (Resident #2) a bath when she (Resident #2) rolled from the bed to the floor. The NA (NA#1) stated she finished the resident's bath, and the resident had an incontinent episode. The NA (NA #1) stated she turned the resident on her left side to provide incontinent care, and the resident was on her side when she (NA#1) reached to get towels. The NA (NA#1) stated that while she was turned around the resident rolled from the bed to the floor. This writer questioned the NA (NA #1) as to whether she was still holding on to the resident while she (Resident #2) was on her side. The NA (NA#1) stated that she was not (still holding onto the resident). The NA (NA#1) stated she had turned around to get towels. The NA (NA#1) was suspended at this time and provided a statement. The employee file indicated the employee skills checklist for providing incontinent care was completed. Review of the resident care plan indicated that the resident required

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assistance with one person for bed baths.

Review of the statement from NA #1 for the fall of 09/18/15 read, " While giving (Resident #2) a bed bath, I turned her over to wash and dry her back. In the process of me reaching for the towel to dry her off, she rolled off the side of the bed. "

Review of the Post-Incident Actions of 09/18/15 read: Narrative of incident: NA (NA#1) reports that she (Resident#1) was turned to her left side and that she (NA) was cleaning her up, had just completed a bed bath and she (NA #1) took her hands off the resident to reach for items and the resident rolled off the side of the bed and fell to the floor. Immediate Post-Incident Action: 2 person assist with bed bath and incontinent care. Immediate Actions Taken: EMS (Emergency Services) Transport to hospital to evaluate for other injuries status post fall.

Review of the attending physician's progress notes of 09/18/15 read: Received call from nursing reporting fall from bed. They describe a large wound on her head and arm with active bleeding and state that her arm is awkwardly behind her. I went to see her (referring to Resident #2) at the nursing home where EMS (Emergency Services) was present and the patient denied back or neck pain. Nursing states that her pupils were large and nonreactive. Nursing reports a fall out of bed, hitting the floor. Objective: Lying on the ground, redness/developing bruise on the face, large ABD pad present on her head, gauze on left wrist. Bandaged as above, pupils constricted 1-2 millimeters bilaterally. Left wrist with bandage present. Assessment and Plan: Patient with fall from bed clearly hitting her head with laceration

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present. Considering severity of fall and blood thinners she clearly needs emergent evaluation. She is in route to the ED (Emergency Department) presently.

Review of the Hospital Emergency Department record of 09/18/15 read: Chief Complaint: Head Laceration. She (Resident #2) presents to the Emergency Room for evaluation after a fall. Patient reportedly was out of bed and hit her head on the air-conditioning unit next to the bed. The patient has a laceration on her head. She is complaining of pain in the head and face area. She was brought to the Emergency Room by Emergency Services. Identified laceration. Review of systems: Skin: Positive for wound. Neurological: Positive for headaches. Musculoskeletal: Normal range of motion. Arms: Skin tear (bilaterally above wrist). Exams (radiology studies) of the pelvis, left forearm, right forearm, left and right hand, right hip, head, maxillofacial, and cervical spine. Impression: No acute fractures. No intracranial hemorrhage.

The care plan updated on 09/18/15 (after the fall) read: Problem/Need: I require staff assistance for all ADL ' s (Activities of Daily Living). Approaches: Two person assist with bath and incontinent care. Bilateral arms and forehead hematoma was added to the Problem/Need onset list.

Observation of Resident #2 was conducted on 10/01/15 at 5:45 PM. The resident was observed in bed, and the bed was in low position. A push bell was noted on the resident's bed directly in front of the resident. The resident had a knot on the left upper forehead, which protruded out approximately 1 inch. There were dark blue bruises noted on both sides of the face on the

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cheeks. The bruises extended from the upper cheek down to the jawbone. The resident was centered in the bed with pillows under the arms and knees.

A staff interview was conducted with the Assistant Director of Nurses (ADON) on 10/01/15 at 5:55 PM. The ADON stated, " We have a Nursing Assistant monitoring her (referring to Resident #2) every 15 minutes."

A direct care staff interview was conducted on 10/01/15 at 6:00 PM with NA #5. NA #5 stated, " I go in there (referring to Resident #2's room) every 15 minutes and ask her if she is okay, or needs anything like need to be changed, thirsty, hungry, hot/cold, pain , or anything. "

A staff interview conducted on 10/02/15 at 1:20 PM with Nurse #1 regarding the circumstances of 09/18/15 when Resident #2 fell from the bed to the floor. Nurse #1 stated, "The resident was receiving AM care, and (NA#1) turned the resident on her side, turned to get a towel, and the resident fell to the floor. The accident occurred around 11:00 AM." When asked if the resident had a history of falls, Nurse #1 indicated, "The resident had a history of falls, but it has been about 6-8 months. She required total care."

A staff interview conducted on 10/02/15 at 1:50 PM with Nurse #2 who was the Charge Nurse at the time of the resident's fall on 09/18/15. Nurse #2 stated, "The Nursing Assistant (NA #1) came and got me from the back chart room. (Na #1) said, ' (Resident #2) fell. I was giving her a bath, and she was on her side. I turned around to get the towels and she fell. ' Nurse #2 stated, " When I went into the room to see what

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happened, the resident was on the floor between the bed and the air conditioner, closer to the air conditioner, and she was lying face down with her head turned to the right side, and her left cheek was on the floor. Her left arm was turned outward away from her body. The back of the left hand was down on the floor and her palm was up. I assessed the resident. She was bleeding from her head, and the blood was streaming on the floor. It looked like she had 2 cuts on her right arm that were bleeding. It appeared that when she fell, she scraped her arm on the air conditioner. I called her name first, because I was not sure if she was conscious or not. I asked if she could hear me and she responded, 'yes'. I asked if she was hurt, and she responded, 'a little'. I checked the arm that was out, and when I touched her, she said, 'Ouch! Be careful'. I was going to try to get a blood pressure, but did not because I was not sure if the arm was broken or not. I told her I was going to get her some help. I told the NA's I was going to call 911. I called the Assistant Director of Nursing, because I knew she was on the next unit over, and could get there quicker. She came around and assessed the resident too. While she was assessing the resident, I went out to call 911 and I called the doctor and told him I had called 911. The resident returned from the hospital before midnight on 09/18/15. "

A staff interview was conducted on 10/02/15 at 2:55 PM with the Assistant Director of Nurses (ADON) the ADON was called to the resident's room by Nurse #2. The ADON indicated, "When I entered the room, I saw (Resident #2) on the floor on her stomach with her head flat on the floor towards her right side. Her left arm was bent at the elbow, but the palm of her hand was flat on

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the floor. The right arm was straight by her side. I did not see any bleeding from her arms. I saw there was a pool of blood under and around her head. I began my assessment, and started talking to the resident. She was able to speak and told me she was not in pain. I explained we were going to put her on a stretcher and send her to the hospital. I proceeded to straighten her left arm/doing range of motion, and she did not express pain with movement of the arm. The Director of Nurses (DON) took over the assessment at that point."

A direct care staff interview was conducted on 10/01/15 at 3:30 PM with the assigned Nursing Assistant (NA #1) who gave the resident AM care prior to the fall on 09/18/15. NA #1 stated, "I was giving her a bed bath and I had all the towels, basin with water on the meal tray table. I had finished the bed bath. She had a diarrhea type stool that continued after I had finished the bed bath. She was on her left side, facing the window, I reached for the towel. As I was reaching for the towel, her body shifted, and it happened so fast, I could not stop the fall. The bed was close to the air conditioner. She didn't have any rails on her bed. Her body weight must have been more turned toward the side she fell. "

A direct care staff interview was conducted on 10/02/15 at 6:10 PM with NA #4, who was usually assigned to (Resident #2). NA #4 stated, "I was off the day she fell. " When asked about movement during care, the NA #4 stated, "She does not move at all unless you turn her or move her. When asked if she can bath the resident by herself, NA #4 said, I feel like I can do her by myself, I feel like I can. But I usually have another person come in to help, to make the

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family feel secure for safety reasons. I do feel one person can give the care. Sometimes when you go to turn her, she will holler in pain and say, "that hurts." Sometimes her left arm swells, and so I get another person to help support her arm when we are turning her. She does not move when we bath her."

A direct care staff interview with NA #2 Medication Aide, was conducted on 10/02/15 at 4:20 PM. NA #2 indicated she was present on the hall where the resident resided when the incident happened. NA #2 stated, "NA #1 came out of the room. I was the first person she saw, and I knew something was wrong, because she (NA #1) was asking me for help. When I got to the doorway, I saw (Resident #2) on the floor, so I backed out of the room and ran to call for the Nurse # 2 to come help. When asked if NA # 1 ever asked NA #2 how many NA's were required to assist the resident. NA # 2 revealed, "I remember her telling me, she wasn't sure on how many people were needed to help bathe the resident. She was telling me she started to go look in the Kardex, but was in a hurry to get (Resident #2) up and dressed, that she just went ahead and did it by herself."

A staff interview was conducted on 10/02/15 at 5:00 PM with the Director of Nurses and the Administrator who revealed, "When we did our investigation, we discovered (NA #1) was giving the resident a bath at the time of the incident, turned around to get a towel, and she said she took her hands off of the resident, and that is why she fell. In-services were done the same day of the fall (09/18/15), which included all nursing staff and nursing assistant staff. We changed the Care Plan to 2 plus person assist for bathing, even

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though the aide who normally has her (NA #4) says she can bathe her by herself. We did an Action Plan which included: Review, update, and revision to the resident's care plan, in-services, assessed and audited bed baths and incontinent care, updated care plan kardexes, and we will bring it to our Quality Assurance meeting. We have not had a Quality Assurance meeting yet. It will be the third Monday in October on October 19, 2015. Our Quality group meets every morning."

An additional interview with the Administrator was conducted on 10/02/15 at 5:40 PM regarding her expectations related to the resident's positioning and subsequent fall, the Administrator stated, "I expect the resident not be injured if a resident is being cared for by a NA. The resident was supposed to be positioned in the middle of the bed with pillows around her, to support her body. We audited everyone in the building for ADL assistance required for bed baths and incontinent care. We updated care plans and kardexes as needed. We did a skills check list on 4/30/15 where (NA #1) did incontinent care. We in-serviced Nursing Assistants. We watched incontinent care to make sure NA#1 was competent to provide services when she was hired on 4/30/15. "

Review of the facility Action Plan after the resident ' s fall of 09/18/15 included development of a monitoring tool entitled, Audit safe rolling during bed bath or incontinent care. Use of the monitoring tool began on 09/21/15, and was in use during the survey of 10/01/15 - 10/02/15. All facility residents had been audited for ADL assistance required for bed baths and incontinent care prior to the survey. The facility also had

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completed an in-service entitled: Preventing rolling from the bed on 09/18/15 with all Nursing Assistants. The content of the in-service read: " When giving a resident a bath, staff are to bear the resident ' s weight when moving the resident from side to side. Keep one hand on the resident when side turning and providing incontinent care to prevent resident from rolling off the bed. Staff should not takes their hands off the resident until the resident is lying on their back in a resting position. Staff should utilize a second staff member as indicated on the Kardex and care plan. The care plan for Resident #2 had been revised on 09/18/15(date of the incident) to read: Two person assist with bath and incontinent care.

A staff interview was conducted on 10/2 /15 at 7:15 PM with Nurse #3 (the weekend supervisor) who indicated, "Due to (Resident # 2) being so weak, she needed 2 person assist with bathing and ADL Care before and after the fall. I would call for someone else to help with turning and doing the incontinent care. Most of the time, she stays in bed."