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F 000	INITIAL COMMENTS A onsite complaint investigation survey was conducted from 01/10/24 through 01/12/24. The survey team entered the facility on 01/10/24 to conduct a complaint investigation survey and exited on 01/12/24. The survey team returned to the facility on 01/17/24 to validate the corrective action plan. Therefore, the exit date was changed to 01/17/24. Event ID#WZQY11. The following intake was investigated NC00211745. 1 of 2 allegations resulted in a deficiency. Intake NC00211745 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J CFR 483.25 at tag F700 at a scope and severity J The tags F689 and F700 constituted Substandard Quality of Care. Non-noncompliance began on 11/19/23. The facility came back in compliance effective 11/20/23. A partial extended survey was conducted.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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

Electronically Signed | 01/29/2024

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F 689	Continued From page 1 Based on observations, record review and interviews with the Emergency Medical Technician, the Medical Doctor, and staff the facility failed to safeguard a resident with severe cognitive impairment from an avoidable hazard when bilateral quarter bed rails were utilized in conjunction with an alternating air pressure mattress. Resident #1 was found with no signs of life on 11/19/23 after experiencing a fall from a bed with bed rails in the up position. The resident was observed with his buttocks on the ground and his head laying face up on the mattress with his chin and neck pressed against the bed rail. This occurred for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: The hospital history and physical dated 09/03/23 revealed Resident #1's diagnoses included generalized weakness and severe dementia. The history and physical included assessment notes completed by the Physical Therapist (PT) and Occupational Therapist (OT). The PT notes provided a list of problems Resident #1 had including decreased cognition, decreased strength and range of motion, and being a fall risk. Resident #1 was admitted to the facility on 09/07/23 with diagnoses including adult failure to thrive and dementia. The admission bed rail assessment dated 09/07/23 signed by Nurse #1 indicated the medical needs considered for the use of the side rails was positioning and indicated Resident #1 would benefit from the use of side rails to aid in positioning. PT and OT were listed on the	F 689	Past noncompliance: no plan of correction required.	

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assessment as the alternatives attempted but failed to meet the needs of Resident #1. None of the potential risks from the use of side rails were checked including if the resident or part of his body would be caught between rails, the opening of rails, or between the bed rails and the mattress. The type of bed rails being used was not included as part of the assessment.

The fall risk evaluation dated 09/07/23 indicated Resident #1 was a high risk for falls.

Review of the admission note dated 09/08/23 revealed Resident #1 was oriented only to self with periods of agitation and aggression. He was incontinent of bowel and bladder and required a mechanical lift for transfers and 2-person assistance with bed mobility and toileting.

The fall care plan initiated on 09/08/23 revealed Resident #1 was at risk for falls related to immobility. Interventions included educate resident and family preventative fall interventions; implement preventative fall interventions and devices; maintain call bell within reach and educate resident to use call bell; physical, occupational, and speech therapy to screen and treat as necessary per physician order; and maintain resident's needed items within reach. There was no care plan to indicate Resident #1 used bed rails for positioning.

The admission Minimum Data Set (MDS) dated 09/12/23 assessed Resident #1's cognition as being severely impaired. Extensive 2-person assistance was needed for bed mobility and toilet use. Assist with transfers occurred 1 to 2 times by extensive 2-person assistance. Walking or locomotion did not occur during the lookback

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period and no falls had occurred since admission. Resident #1 was always incontinent of bladder and bowel. The assessment indicated bed rails were not being used as a physical restraint.

The admission Care Area Assessments for the MDS dated 09/12/23 described Resident #1 would be long term care due to his cognition and was a fall risk due to poor safety awareness and limited mobility. Staff assistance was needed for incontinence due to mobility and cognition and needed for repositioning to relieve pressure due to being at risk for pressure ulcers. It was noted Resident #1 had demonstrated verbal and physical behaviors described as grabbing at bars and the mechanical lift.

The incident report documented by the nurse on 09/27/23 revealed a skin assessment identified Resident #1 had a new pressure ulcer wound on the sacrum.

A second bed rail assessment dated 09/27/23 completed by Nurse #1 revealed no changes were made to the assessment and indicated Resident #1 would benefit from the use of side rails to aid in positioning and alternatives attempted that failed were PT and OT. None of the potential risks from the use of side rails were checked including: The resident or part of his body would be caught between rails, the opening of rails, or between the bed rails and the mattress or skin integrity issues. The type of bed rails being used was not included as part of the assessment.

Review of the delivery order revealed on 10/04/23 an alternating pressure mattress was placed on the bed of Resident #1.

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There was no bed rail assessment completed for Resident #1 from 10/04/23 through 11/19/23.

Resident #1 was discharged to the hospital on 11/14/23 for the chief complaint emesis and possible coffee ground colored emesis. Resident #1 was discharged back to the facility on 11/16/23.

Review of the progress note written by Nurse #2 on 11/19/23 at 7:55 AM revealed she was alerted by Nurse Aide (NA) #1 Resident #1 partially fell from the bed. Resident #1 was assessed with no pulse present and Emergency Medical Services (EMS) was called. The on-call Nurse Practitioner for the Medical Doctor and Administration were notified.

Review of the EMS incident report revealed on 11/19/23 at 5:30 AM Resident #1 had fallen from the bed. The lead Emergency Medical Technician (EMT) documented narrative read in part, "EMS was dispatched for a fall and when arrived on the scene was met by and followed facility staff to the room. While walking to the room staff on the scene advised the patient was gone and they had found him lying halfway off the bed and his head was stuck in the railing." The EMT found Resident #1 lying on the floor in a supine position (flat on one's back) and described the resident as apneic (without breaths), pulseless and the skin was pale and cool to touch. The note indicated the EMT was advised by staff Resident #1 was last seen at 3:15 AM and found at 5:30 AM in the initial position described. At 6:32 AM the EMS assessment of a cardiac monitoring device showed an asystole (without a heartbeat) heart rhythm.

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A telephone interview was conducted on 1/11/24 at 2:13 PM with the lead EMT who wrote the narrative on the EMS report. The EMT confirmed Resident #1 was laying on the floor in supine (flat on one's back) position when they entered the room. He stated the call came in as fall and when they arrived at the facility a staff member, he was unable to identify, walked him to the room and said Resident #1 was gone and was Do Not Resuscitate. He thought it was the same person who told him Resident #1's head was stuck in the bed rail and confirmed that was said to him. During the assessment of Resident #1 he did not notice any bruising or impression of a bed rail on the resident or see anything that stood out to him.

Review of the facility's investigation revealed a statement from NA#1 dated 11/19/23 that read in part, "Doing my 5:00 AM rounds I noticed resident was on the floor in between the bed rail. I went to notify the nurse. The last time I did a round was at 3:00 AM. I changed resident and he was laying down on his back." A clarification was made to NA #1's statement dated 11/19/23 and read in part, "At 3:00 AM I went in the room to change brief and Resident #1 was laying on his back holding the rail and fighting as usual. His left leg was coming out of the bed. I redirected his arms to the right side to hold onto the rail so I could change his brief. When I left the room put the bed in the lowest position. At 5:15 AM I walked into Resident #1's room and noticed he was laying with jaw line in rail and his body was on left side of bed on floor with his brief halfway off with the sheets and some his blanket. I walked over to see if his chest was rising up and down and noticed it wasn't. I went out of the room to find nurse. She and I walked back to room, and she confirmed

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Resident #1 was deceased. I assist to get into the bed with other NAs." Other staff statements included in the investigation did not provide information related to the position they saw Resident #1 after being made aware he had passed and before his body was moved.

During a telephone interview on 01/11/24 at 1:29 PM Nurse #1 confirmed she had completed the bed rail assessments for Resident #1. She explained if a resident was cognitively impaired, climbed out of bed, was a high fall risk or did not understand why or how they would use a bed rail she would not recommend rails and stated Resident #1 was not like that. Nurse #1 stated Resident #1 had dementia but most of the time he was able to use the bed rails. She reported he had a rapid decline after developing a pressure ulcer on his sacrum.

During a telephone interview on 1/10/24 at 4:33 PM NA #1 confirmed she worked the night shift on 11/18/23 from 6:45 PM to 7:15 AM the morning of 11/19/23 and was assigned to care for Resident #1. NA #1 stated when she found Resident #1 (5:15 AM), he was laying on his left side towards the window with the left leg bent under his right leg and his buttocks was on the floor. His lower body was lying on the floor, but his head was on the bed face up and his jaw was leaning and/or pressing into the rail but not in between the rails. The air mattress was on the bed and the bed was always kept low to ground, and the bed rail was in an up position. She went around the bed and put her hand on Resident #1's chest to check for breathing and he wasn't. She left the room and did not see the nurse and got NA #2. NA #2 did not enter the room but stated she could tell Resident #1 was dead and

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they (NA #1 and NA #2) both went to find the nurse. NA #1 stated she last changed Resident #1 around 3:30 AM and her next check was around 5:15 AM and that's when she found him. She was told by Nurse #2 not to move Resident #1 until the Administrator came to the facility. NA #1 stated it did not appear Resident #1 was stuck in the bed rail or between the rail and mattress. She stated Resident #1 was combative with care and was a 2-person assist and needed a mechanical lift for transfer. She revealed Resident #1 would grab onto the bed rails, but he did not follow cues to use the bed rail and pull himself over onto his side for bed mobility.

During a telephone interview on 01/10/24 at 5:48 PM Nurse #2 revealed she was the assigned nurse for Resident #1 on the night of 11/18/23 to morning of 11/9/23. Nurse #2 revealed she was not very familiar with Resident #1 and been his assigned nurse a few times prior to the incident. She described during her conversations with Resident #1 he did not make sense and was confused. During her shift on the morning of 11/19/23 NA #1 said she needed to come to the room and when she entered, she walked around the bed to the side by window and found Resident #1 halfway on the floor and halfway on the bed and described Resident #1 was sitting on his buttocks on the floor with his arms bedside him and his back up against the side of the bed. His head was laying on the mattress facing up and his chin and neck were against the bed rail. She checked for a pulse and described Resident #1 felt warm to touch but had no pulse. She asked Nurse #3 if she would check Resident #1 and stated Nurse #3 did not find a pulse. Nurse #3 told her to call the Administrator then EMS and that was what she did. The Administrator told her

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not to move Resident #1. Nurse #2 revealed she spoke to EMS on the phone to give a report and only recalled telling them Resident #1 was not breathing and was on the floor. The Administrator arrived approximately 7 minutes later and took over the situation and Nurse #2 stated she continued with her medication administration pass.

A telephone interview was conducted on 01/11/24 at 9:25 AM with NA #2. NA #2 stated on the morning of 11/19/23 NA #1 told her Resident #1 slid out of bed and asked if she could help. NA #2 stated when she got to the door, she could see the top half of Resident #1's body was on the bed and his buttocks was on the floor with his back was against the side of the bed and bed was in lowest position to floor. NA #2 stated she did not walk in the room but saw Resident #1's face and could tell he was deceased because his eyes were open. She stated the left part of Resident #1's head was at the edge of the rail, but she could not say it was stuck in the rail or the rail kept him from falling to the floor and stated it was hard for her recall and she was having a difficult time trying to picture what she saw. NA #2 revealed she had provided care for Resident #1 before the incident and stated usually it took 2 to 3 persons because he was combative during care. When first admitted (9/7/23) and before going to the hospital (11/14/23) she stated Resident #1 followed cues and would grab the bed rail and pull himself over during care but after coming back from the hospital (11/16/23) that's when the behaviors increased, and he needed more staff due to increased behaviors and didn't follow cues.

A telephone interview was conducted on 01/11/24

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at 11:26 AM with Nurse #3. Nurse #3 stated Nurse #2 requested she come and help assess Resident #1 on the morning of 11/19/23 and asked what she needed to do. Nurse #3 stated it was obvious Resident #1 had expired because he had no respirations, and his skin coloring was very pale. Nurse #3 stated she listened for respirations and checked for a pulse and Resident #1 had neither and advised Nurse #2 to call the Administrator. Nurse #3 described what she saw when she entered the room and stated the top half of Resident #1's body was on the mattress and his lower body was on the floor with his legs out and facing the window. Nurse #3 stated Resident #1's left shoulder and neck were braced into the bed rail, and it appeared he was caught in the rail. Nurse #3 stated the bed was in the lowest position to the floor and it was alarming to her seeing Resident #1 braced against the bed rail and it appeared to her the bed rail kept Resident #1 from sliding off the bed onto the floor.

A telephone interview was conducted on 01/10/24 at 1:46 PM with Medication Aide (MA) #1 who worked on the same unit Resident #1 was located on the night of 11/18/23 through the morning of 11/19/23. MA #1 stated she did not see Resident #1 that night until NA #2 told her he passed away. MA #1 revealed the staff on the unit went to see what happened and stated what she saw was Resident #1's head between the mattress and bed rail and he was half in the bed and half out the bed. She stated it appeared to her Resident #1 was trapped in the bed rail, and the bed rail kept him from falling to the floor. MA #1 revealed staff had to anticipate Resident #1's care needs and he did not use the call light to request care and was a 2-person assist with care. She

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revealed Resident #1 would grab the bed rail and not let go as a behavior, but he did not use them to reposition for mobility during care.

During an interview on 01/10/24 at 4:06 PM the Administrator stated she did the investigation for the incident that occurred on morning of 11/19/23 with Resident #1. She reported she came to the facility after being notified by Nurse #2. The Administrator described the position she saw Resident #1 and stated his legs were on the floor and the left side of his head was resting on the air mattress and his chin was on the bed rail, but it did not appear stuck in the rail. She stated Resident #1 had a large bowel movement and had pulled the brief halfway off and it was thought with his history of cardiac issues and having a large bowel movement he had a vagal (vasovagal syncope triggered by a reaction to something causing a drop in blood pressure and heart rate causing loss of consciousness) response and passed.

During a follow-up interview on 01/11/24 at 1:06 PM and at 3:22 PM the Administrator stated Resident #1 did not have a significant change in his physical mobility and used the bed rails to grab onto during incontinent changes and as a security he liked to hold on to the bed rail. She stated she saw a potential risk with entrapment in the bed rail on 11/19/23, and reiterated Resident #1 was not entrapped but she did come to the facility to investigate. Her investigation included statements from staff and bed rail safety assessments and removal of bed rails no longer necessary.

During a telephone interview on 01/16/24 at 1:04 PM the Medical Doctor (MD) reviewed his notes

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and stated Resident #1 required extensive assistance from staff for activities of daily living and was cognitively impaired and he questioned the ability Resident #1 could physically use the bed rail and if the resident had the cognitive awareness to be safe when using the bed rails. He explained a bedside assessment would need to be done that provided information related to Resident #1's ability to move in bed and if not, he would raise the questions if bed rails were beneficial if the resident could not turn himself while in bed and was dependent on staff for assistance with bed mobility. The MD stated if Resident #1 could use the bed rails and was able to grab hold and follow cues with staff assistance to roll over, then bed rails would be beneficial but based on the therapy's information he would question if Resident #1 had the strength to move himself and safely reposition. He stated if a resident refused to participate in therapy, he would expect a significant decline in their ability to perform activities of daily living and at that point a review of the care plan would need to be done and that would include reviewing the need for bed rails. The MD stated he would expect the bed rail assessment would identify how a resident would use the bed rail to benefit themselves such as could they grab hold and physically turn themselves using the bed rail. The MD stated if a patient could grab the bed rail but was too weak to physically use it to reposition or free themselves if needed, he would question if bed rail was beneficial and would expect staff were trained to recognize residents that could or could not use bed rails. The MD stated based on therapy notes and the bed rail assessments it sounds like there were inconsistencies with Resident #1's capability that he could use the bed rail for mobility. For cognitively impaired residents

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the MD stated he would question if they were capable of safely using the bed rail and could free themselves if there was a situation, they were against the bed rail.

On 01/12/24 at 9:01 PM the Administrator was notified of Immediate Jeopardy.

The facility provided the following corrective action plan with the completion date of 11/20/23:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #1 expired on 11/19/23.

On 11/19/2023, facility IDT team completed an investigation for the alleged incident, the regional clinical nursing team reviewed the investigation in full.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 11/19/2023, the Interdisciplinary Team (IDT) team, which included: Social Services (SSW), Nursing, Therapy and Maintenance, completed a facility sweep and identified all residents that had bedrails and air mattresses.

On 11/19/2023, bed rails assessments were reviewed/completed on all residents. 10 residents had bed rails removed based on new bed rail assessment.

On 11/19/2023, IDT reviewed care plans related to bed rails and updates made to the care plan as

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indicated, licensed nursing staff and Certified Nursing Aide staff were updated on changes to care plans.

On 11/19/2023 and will be updated immediately on any future changes to care plan.

On 11/19/2023, the Director of Nursing (DON)/Designee reviewed all residents with an air mattress to ensure that they were appropriate based on recommendations from provider for wound healing, comfort, and/or pain management. Only one other resident has an air mattress that was recommended by the provider for pain control related to an unstageable wound and prevention of worsening of that wound for that resident at end of life. This intervention was determined to be appropriate for this resident, this resident did not have bed rails.

On 11/19/2023, the SSW/Designee called and explained the risks and benefits of the bed rails to appropriate residents and or responsible parties and obtained the informed consent.

On 11/19/2023, DON/Designee reviewed and updated the restraint decision trees for the side rails as per company policy.

On 11/19/2023, the Maintenance supervisor/designee completed the Bed and Bed Rail Safety Inspection on all beds in the facility per company bed safety inspection policy and Food and Drug Administration (FDA) Bed Dimensional Limit recommendations. - No negative findings.

On 11/19/2023, the Minimum Data Set (MDS) nurse/designee reviewed all care plans to ensure

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bed rails, and specialized air mattress was care planned appropriately.

On 11/19/2023, facility IDT team completed an investigation for the alleged incident, the regional clinical nursing team reviewed the investigation in full.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Education 11/19/2023:
On 11/19/2023, the Licensed Nursing Home Administrator (LNHA) educated the maintenance supervisor on Bed Identification and Safety Inspection Policy

On 11/19/2023, the LNHA educated the DON on the Bed Rail Policy and Restraint Policy

On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and bed identification and safety inspection policy.

On 11/19/2023, the LNHA educated all staff on entrapment, restraints, and neglect.

On 11/19/2023, the LNHA/Designee educated all in house nursing staff on how to complete a bed rail assessment accurately as well as the restraint decision tree assessment, this would guide nursing staff in the decision to add bed rails based the bed rail assessment. Licensed nursing staff will complete a bed rail assessment to determine resident's ability and need for bed rail utilization, this assessment will be done on admission and periodically as needed, including any significant ADL change.

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F 689	Continued From page 15 On 11/19/2024 Education on following physician orders, as well as ensuring that the resident is able to utilize the bed rails was completed with all licensed nursing staff. On 11/19/2023, education provided with all staff on appropriate linen for air mattresses. All facility staff was educated either in person or by phone and education was completed on 11/19/2023. Ongoing education will be provided to all newly hired staff as well as any agency staff. On 11/19/2023, LNHA educated the IDT and Nursing team on notification of new mattress and ensuring that maintenance/designee is aware, and assessment is completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Ongoing Quality Assurance and Performance Improvement: 11/19/2023, DON/Designee will audit new admissions for bed rail assessments weekly x 4 weeks, then monthly x 2 months 11/19/2023, LNHA/Designee will audit any bed frame, mattress changes, or any changes to bed rails to ensure that the bed safety inspection has been completed, weekly x 4 weeks, then monthly x 2 months. 11/19/2023, the results of the audits to be forwarded to the facility Quality Assurance and Performance Improvement (QAPI) committee for	F 689		

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F 689	Continued From page 16 further review and recommendations. Ad hoc QAPI meeting held with the DON, LNHA and Medical Director, RDCS, and the ID team on to review the event and the QAPI plan put in place 11-20-2023. No additional recommendation. Alleged date of compliance: 11/20/23 The correction action plan was validated on 01/17/24 and concluded the facility had implemented an acceptable corrective action plan on 11/20/23 once staff education was completed and the corrective action plan was reviewed and implemented during a QAPI meeting held on 11/20/23. Interviews with staff, including agency staff, revealed the facility had provided education on the facility's bed rail policy, safety inspection policy, entrapment, restraints, and neglect. Licensed nursing staff were able to verbalize when and how to complete a bed rail assessment to determine the resident's ability and need for bed rail utilization and who to inform when residents no longer needed bed rails. Nursing staff were also able to verbalize checking for proper fit of the mattress with the bed rail to ensure there were no gaps or other risks for injury and who they inform if any concerns were identified. Observations conducted of all beds in the facility revealed bed rails were not installed on the bed unless the resident had a bed rail assessment and safety inspection completed before installation of the bed rails. Review of the monitoring tools that began on 11/24/23 were completed weekly/monthly as outlined in the corrective action plan with no concerns identified.	F 689		
F 700 SS=J	Bedrails	F 700		

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F 700	Continued From page 17 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with the Emergency Medical Technician, the Medical Doctor, and staff the facility failed to comprehensively assess the risk of entrapment and the use of quarter length bilateral bed rails for a dependent resident with severe cognitive impairment who required extensive 2-person assistance with bed mobility after the placement of an alternating pressure air mattress. The resident experienced a fall from the bed equipped with the alternating pressure air mattress and quarter rails on both sides of the bed in an up position. The resident was found	F 700	Past noncompliance: no plan of correction required.	

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with no signs of life and observed to be partially on the floor and partially on the bed with his head pressed against the bed rail. This deficient practice occurred for 1 of 3 residents reviewed for bed rails (Resident #1).

Findings included:

The hospital history and physical dated 09/03/23 revealed Resident #1's diagnoses included generalized weakness and severe dementia. The Physical Therapist (PT) and Occupational Therapist (OT) notes indicated Resident #1 had decreased cognition, decreased strength and range of motion, as being a fall risk; and was able to minimally assist using bed rails to roll and reposition but unable to hold a position and needed physical assistance by 2-person to scoot up in bed.

Resident #1 was admitted to the facility on 09/07/23 with diagnoses including adult failure to thrive and dementia.

The admission bed rail assessment dated 09/07/23 indicated the medical needs considered for the use of the side rails was positioning and Resident #1 would benefit from the use of side rails to aid in positioning. PT and OT were listed on the assessment as the alternatives attempted but failed to meet the needs of Resident #1. None of the potential risks from the use of side rails were checked including:
2. The resident or part of his body would be caught between rails, the opening of rails, or between the bed rails and the mattress.
6. Decline in function such as muscle functioning and balance.
7. Skin integrity issues.

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8. Decline in other areas of daily living such as using the bathroom, continence, eating, hydration, walking, and mobility.
11. Induces agitation or anxiety.
The assessment (dated 09/07/23) indicated the information was presented to the representative of Resident #1 and informed consent was obtained prior to installing the bed rail on 09/08/23. The bed rail assessment used did not include the use of an air mattress as a risk for entrapment or type of bed rails used. The assessment was signed by Nurse #1.

Review of the admission note dated 09/08/23 revealed Resident #1 was oriented only to self with periods of agitation and aggression. He was incontinent of bowel and bladder and required a mechanical lift for transfers and 2-person assistance with bed mobility and toileting.

A fall care plan initiated on 09/08/23 revealed Resident #1 was at risk for falls related to immobility. Interventions included educate resident and family preventative fall interventions; implement preventative fall interventions and devices; maintain call bell within reach and educate resident to use; PT/OT/Speech Therapy (ST) to screen and treat as necessary per physician order; and maintain resident's needed items within reach. There was no care plan to indicate Resident #1 used bed rails for positioning.

Review of the PT progress notes for the initial evaluation dated on 09/08/23 revealed Resident #1 was unable to provide his mobility ability due to his cognitive status. Resident #1's baseline for transfers indicated he was totally dependent, and the PT recommended the use of mechanical lift.

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The note indicated the PT was unable to assess bed mobility and wheelchair mobility due to Resident #1 refusing.

The admission Minimum Data Set (MDS) dated 09/12/23 assessed Resident #1 as being severely impaired cognitively and needed extensive 2-person assistance with bed mobility and toilet use and transfers occurred 1 to 2 times using extensive 2-person assistance. Walking, or locomotion did not occur during the lookback period and no falls had occurred since admission. Resident #1 was always incontinent of bladder and bowel and bed rails were not being used as a restraint.

The Care Area Assessments for the admission MDS dated 09/12/23 described Resident #1 would be long term care due to his cognition and was a fall risk due to poor safety awareness and limited mobility. Staff assistance was needed for incontinence due to mobility and cognition and for repositioning to relieve pressure due to being at risk for pressure ulcers.

Review of the PT progress notes revealed on 09/21/23 Resident #1 was discharged from PT services for refusing treatment. His functional abilities on discharge to safely perform bed mobility tasks revealed he was totally dependent and required 100% of tactile (physical touch) cueing. In summary Resident #1 was discharged from therapy, "due to poor motivation and participation due to cognitive status and dementia techniques used to increase participation were not working."

The incident report documented by the nurse on 09/27/23 revealed a skin assessment identified

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Resident #1 had a new pressure ulcer wound on the sacrum.

A second bed rail assessment dated 09/27/23 revealed no changes were made to the assessment and indicated Resident #1 would benefit from the use of side rails to aid in positioning and alternatives attempted that failed were PT and OT. None of the potential risks from the use of side rails were checked including skin integrity issues or decline in other areas of daily living such as mobility. Informed consent was obtained from the representative of Resident #1 on 09/28/23. The bed rail assessment did not include the use of an air mattress as a risk for entrapment or type of bed rails used. The assessment was signed by Nurse #1.

During a telephone interview on 01/11/24 at 1:29 PM Nurse #1 confirmed she had completed both the admission (09/07/23) and second bed rail assessment (9/27/23) for Resident #1 and stated he was able to use bed rails for turning and repositioning and they did not restrict him. Nurse #1 explained she completed the bed rail assessments and reviewed if rails were beneficial or put the resident at risk. She explained if a resident was cognitively impaired, climbed out of bed, was a high fall risk or did not understand why or how they would use a bed rail she would not recommend. Nurse #1 stated Resident #1 had dementia and was unable to consent and recalled the Responsible Party (RP) was present during the admission bed rail assessment and agreed bed rails would make Resident #1 safer. Nurse #1 stated most of the time Resident #1 was able to use the bed rails but had a rapid decline after developing a pressure ulcer on his sacrum.

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Review of the delivery order dated 10/04/23 revealed an alternating pressure mattress was placed on the bed of Resident #1.

Review of a nurse note written on 11/20/23 revealed the nurse spoke to the company who delivered and placed the alternating pressure air mattress on the bed for Resident #1. The note indicated the representative from the company assured the mattress placed on the bed of Resident #1 would fit any standard bed frame and there was no contraindication for the use of side rails, and it could be used with or without rails.

There was no bed rail assessment completed for Resident #1 when the alternating pressure air mattress was placed on the bed from 10/04/23 through 11/19/23.

Resident #1 was discharged to the hospital on 11/14/23. The hospital notes indicated Resident #1 was unable to provide any history due to advanced dementia and was receiving wound care for a pressure ulcer on the sacrum. Resident #1 was discharged back to the facility on 11/16/23.

A telephone interview was conducted on 01/11/24 at 9:25 AM with Nurse Aide (NA) #2. NA #2 stated when first admitted (9/7/23) and before going to the hospital (11/14/23), Resident #1 followed cues and would grab the bed rail and pull himself over during care but after coming back from the hospital that's when the behaviors increased, and he needed more staff to assist with activities of daily living and he did not follow cues.

Review of the palliative care Nurse Practitioner

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progress note dated 11/17/23 revealed Resident #1 was referred for symptom management and medical decision making related to dementia and for a wound on the sacrum. The note indicated he remained total care and was bedbound requiring a mechanical lift for transfer but was not currently getting out of bed.

A telephone interview was conducted on 01/10/24 at 1:46 PM with Medication Aide (MA) #1 who worked on the same unit Resident #1's room was located during her shift on the night of 11/18/23 through the morning of 11/19/23. MA #1 stated she did not see Resident #1 that night until NA #2 told her he passed away the next morning on 11/19/23. MA #1 revealed the staff on the unit went to see what happened and stated what she saw was Resident #1's head between the mattress and bed rail and he was half in the bed and half out the bed. She stated it appeared to her Resident #1 was trapped in the bed rail, and the bed rail kept him from falling to the floor. MA #1 revealed staff had to anticipate Resident #1's care needs and he did not use the call light to request care and was a 2-person assist with care. She revealed Resident #1 would grab the bed rail and not let go as a behavior, but he did not use them to reposition for mobility during care.

Review of the facility's investigation revealed a statement from NA#1 dated 11/19/23 that read in part, "Doing my 5:00 AM rounds I noticed resident was on the floor in between the bed rail. I went to notify the nurse. The last time I did a round was at 3:00 AM. I changed resident and he was laying down on his back." A clarification was made to NA #1's statement dated 11/19/23 and read in part, "At 3:00 AM I went in the room to change brief and Resident #1 was laying on his back holding

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the rail and fighting as usual. His left leg was coming out of the bed. I redirected his arms to the right side to hold onto the rail so I could change his brief. When I left the room put the bed in the lowest position. At 5:15 AM I walked into Resident #1's room and noticed he was laying with jaw line in rail and his body was on left side of bed on floor with his brief halfway off with the sheets and some his blanket. I walked over to see if his chest was rising up and down and noticed it wasn't. I went out of the room to find nurse. She and I walked back to room, and she confirmed Resident #1 was deceased. I assist to get into the bed with other NAs." Other staff statements included in the investigation did not provide information related to the position they saw Resident #1 after being made aware he had passed and before his body was moved.

During a telephone interview on 1/10/24 at 4:33 PM NA #1 confirmed she worked on the night of 11/18/23 from 6:45 PM to 11/19/23 at 7:15 AM and was assigned to care for Resident #1. NA #1 stated when she found Resident #1, he was laying on his left side towards the window with the left leg bent under right leg and his buttocks sitting on the floor. His lower body was lying on the floor, but his head was on the bed face up and his jaw was leaning and/or pressing into the rail but not in between the rails. She stated the air mattress was on the bed, quarter bilateral rails were up, and the bed was always kept low to ground. She stated Resident #1 was combative with care and was a 2-person assist with care and needed a mechanical lift for transfer. She described when she provided care Resident #1 would grab onto the bed rails and not let go was a behavior, but he did not follow cues to use the bed rail and pull himself over onto his side for bed

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mobility.

Review of the progress note written by Nurse #2 on 11/19/23 at 7:55 AM revealed she was alerted by NA #1 that Resident #1 partially fell from the bed. Resident #1 was assessed with no pulse and Emergency Medical Services (EMS) was called. The on-call Nurse Practitioner for the Medical Doctor and Administration were notified.

During a telephone interview on 01/10/24 at 5:48 PM Nurse #2 confirmed she was the assigned nurse for Resident #1 on the night of 11/18/23 through the morning of 11/19/23. Nurse #2 revealed she was not very familiar with Resident #1 and had only been his assigned nurse a few times. She described during her conversations with Resident #1 he did not make sense and was confused. During her shift on the morning of 11/19/23 NA #1 said she needed to come to the room and when she entered, she walked around the bed to the side by window and found Resident #1 halfway on the floor and halfway on the bed and described Resident #1 was sitting on his buttocks on the floor with his arms bedside him and his back up against the side of the bed. His head was laying on the mattress facing up and his chin and neck were against the bed rail. She checked for a pulse and described Resident #1 felt warm to touch but had no pulse. She asked Nurse #3 if she would check Resident #1 and stated Nurse #3 did not find a pulse. Nurse #3 told her to call the Administrator then EMS and that was what she did.

A telephone interview was conducted on 01/11/24 at 11:26 AM with Nurse #3. Nurse #3 described what she saw on the morning of 11/19/23 when she entered the room and stated the top half of

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Resident #1's body was on the mattress and his lower body was on the floor with his legs out and facing the window. Nurse #3 stated Resident #1's left shoulder and neck were braced into the bed rail, and it appeared he was caught in the rail. Nurse #3 stated the bed was in the lowest position to the floor and it was alarming to her seeing Resident #1 braced against the bed rail and it appeared to her the bed rail kept Resident #1 from sliding off the bed onto the floor.

Review of the EMS incident report revealed on 11/19/23 at 5:30 AM Resident #1 had fallen from the bed. The lead Emergency Medical Technician (EMT) documented narrative read in part, "EMS was dispatched for a fall and when arrived on the scene staff reported they found Resident #1 lying halfway off the bed and his head was stuck in the railing." The EMT noted they found Resident #1 lying on the floor in a supine position (flat on one's back) and described the resident as apneic (without breaths), pulseless, and the skin was pale and cool to touch.

A telephone interview was conducted on 1/11/24 at 2:13 PM with the lead EMT who wrote the narrative on the EMS report. The EMT confirmed Resident #1 was laying on the floor in supine (flat on one's back) position when they entered the room. He stated the call came in as fall and when they arrived at the facility a staff member reported Resident #1's head was stuck in the bed rail. During the assessment of Resident #1 he did not notice any bruising or impression of a bed rail on the resident or see anything that stood out to him.

During an interview on 01/11/24 at 1:18 PM the Maintenance Director stated he had worked at the facility for approximately one- and one-half

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years and the bed rail safety inspection audit dated 11/19/23 was the first one he had done since his employment. He stated he was unable to find documentation or records of bed rail safety inspections being done prior to the new company taking over. He reported either him or the Maintenance Assistant placed bed rails but could not recall if he placed the rails on Resident #1's bed. He stated after Resident #1's fall he conducted bed rail safety inspections and used the bed rail assessment tool to conduct those on all beds with rails and would be done annually or as needed including when a new mattress/air mattress was placed. He confirmed maintenance was responsible for completing the bed safety inspections and installing bed rails. He stated he completed a bed rail safety inspection on 11/19/23 for Resident #1 with the air mattress in place and inflated and there were no negative findings based on the guidelines of the facility's assessment tool used. He stated there were times beds were switched out if it stopped working and a resident might be put in a bed with rails.

During an interview on 01/11/24 at 3:22 PM the Administrator revealed a company used by the facility placed the air mattress on the bed and it was placed to assist Resident #1 with repositioning due to him having a pressure ulcer on his sacrum. She stated she did recognize there was a potential risk for entrapment related to the fall on 11/19/23 and reiterated Resident #1 was not trapped in the bed rail. She started an investigation and identified one other resident with an air mattress, but the bed did not have rails in place. She revealed the Interdisciplinary Team (IDT), and nursing staff were educated to report any mattress changes to maintenance and if bed

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rails were in place a safety inspection was completed and she continued her audits to identify any mattress changes and beds with rails. She revealed either the Maintenance Director or Maintenance Assistant was responsible for checking the bed rails using the safety inspection tool but had no records to show bed rail safety checks were done for Resident #1 prior to 11/19/23.

During a telephone interview on 01/16/24 at 1:04 PM the Medical Doctor (MD) stated Resident #1 required extensive assistance from staff for activities of daily living and was cognitively impaired. The MD stated he would question Resident #1's abilities to physically use the bed rail and if the resident had the cognitive awareness to be safe when using the bed rails. He explained a bedside assessment would need to be done that provided information related to Resident #1's abilities to move in bed and if not, he would raise the question if bed rails were beneficial. The MD stated based on therapy notes and the bed rail assessments it sounded like there were inconsistencies with Resident #1's capability that he could use the bed rail for mobility. For cognitively impaired residents the MD stated he would question if they were capable of safely using the bed rail and could free themselves if there was a situation when they were against the bed rail.

On 01/12/24 at 5:02 PM the Administrator was notified of immediate jeopardy.

The facility provided the following corrective action plan with the correction date of 11/20/23:

Address how corrective action will be

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accomplished for those residents found to have been affected by the deficient practice;

Resident #1 expired on 11/19/2023.

On 11/19/2023, facility IDT team completed an investigation for the alleged incident, the regional clinical nursing team reviewed the investigation in full.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

On 11/19/2023, the IDT team, which included: Social Services, Nursing, Therapy and Maintenance, completed a facility sweep and identified all residents that had bedrails and air mattresses.

On 11/19/2023, bed rails assessments were reviewed/completed on all residents. 10 residents had bed rails removed based on new bed rail assessment.

On 11/19/2023, IDT reviewed care plans related to bed rails and updates made to the care plan as indicated, licensed nursing staff and CNA staff were updated on changes to care plans on 11/19/2023 and will be updated immediately on any future changes to care plan.

On 11/19/2023, the DON/Designee reviewed all residents with an air mattress to ensure that they were appropriate based on recommendations from provider for wound healing, comfort, and/or pain management. Only one other resident has an air mattress that was recommended by the provider for pain control related to an unstageable

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wound and prevention of worsening of that wound for that resident at end of life. This intervention was determined to be appropriate for this resident, this resident did not have bed rails.

On 11/19/2023, the SSW/Designee called and explained the risks and benefits of the bed rails to appropriate residents and or responsible parties and obtained the informed consent.

On 11/19/2023, DON/Designee reviewed and updated the restraint decision trees for the side rails as per company policy.

On 11/19/2023, the Maintenance supervisor/designee completed the Bed and Bed Rail Safety Inspection on all beds in the facility per company bed safety inspection policy and FDA Bed Dimensional Limit recommendations. - No negative findings.

On 11/19/2023, the MDS nurse/designee reviewed all care plans to ensure bed rails, and specialized air mattress was care planned appropriately.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Education 11/19/2023:
On 11/19/2023, the LNHA educated the maintenance supervisor on Bed Identification and Safety Inspection Policy

On 11/19/2023, the LNHA educated the DON on the Bed Rail Policy and Restraint Policy

On 11/19/2023, the LNHA educated all staff on

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Bed Rail Policy and bed identification and safety inspection policy.

On 11/19/2023, the LNHA educated all staff on entrapment, restraints and neglect.

On 11/19/2023, the LNHA/Designee educated all in house nursing staff on how to complete a bed rail assessment accurately as well as the restraint decision tree assessment, this would guide nursing staff in the decision to add bed rails based the bed rail assessment. Licensed nursing staff will complete a bed rail assessment to determine resident's ability and need for bed rail utilization, this assessment will be done on admission and periodically as needed, including any significant ADL change.

On 11/19/2024 Education on following physician orders, as well as ensuring that the resident is able to utilize the bed rails was completed with all licensed nursing staff.

On 11/19/2023, education provided with all staff on appropriate linen for air mattresses.

All facility staff was educated either in person or by phone and education was completed on 11/19/2023. Ongoing education will be provided to all newly hired staff as well as any agency staff.

On 11/19/2023, LNHA educated the IDT and Nursing team on notification of new mattress and ensuring that maintenance/designee is aware, and assessment is completed.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

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F 700	Continued From page 32 Ongoing Quality Assurance and Performance Improvement: 11/19/2023, DON/Designee will audit new admissions for bed rail assessments weekly x 4 weeks, then monthly x 2 months 11/19/2023, LNHA/Designee will audit any bed frame, mattress changes, or any changes to bed rails to ensure that the bed safety inspection has been completed, weekly x 4 weeks, then monthly x 2 months. 11/19/2023, the results of the audits to be forwarded to the facility QAPI committee for further review and recommendations. Ad hoc QAPI meeting held with the DON, LNHA and Medical Director, RDCS, and the ID team on to review the event and the QAPI plan put in place 11-20-2023. No additional recommendation. Alleged date of compliance: 11/20/23 The Corrective Action plan was validated on 01/17/24 and concluded the facility had implemented an acceptable corrective action plan on 11/20/23 once staff education was completed and the corrective action plan was reviewed and implemented during a QAPI meeting held on 11/20/23. Interviews with staff, including agency staff, revealed the facility had provided education on the facility's bed rail policy, safety inspection policy, entrapment, restraints, and neglect. Licensed nursing staff were able to verbalize when and how to complete a bed rail assessment to determine the resident's ability and need for	F 700		

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bed rail utilization and who to inform when residents no longer needed bed rails. Nursing staff were also able to verbalize checking for proper fit of the mattress with the bed rail to ensure there were no gaps or other risks for injury and who they inform if any concerns were identified. Observations conducted of all beds in the facility revealed bed rails were not installed on the bed unless the resident had a bed rail assessment and safety inspection completed before installation of the bed rails. Review of the monitoring tools that began on 11/24/23 were completed weekly/monthly as outlined in the corrective action plan with no concerns identified.