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F 000	INITIAL COMMENTS The survey was done 9/28/12 - 10/3/12. Tag F323 was modified in scope and severity in a settlement negotiation with the Centers for Medicare & Medicaid Services.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, emergency medical staff, staff and physician interviews, the facility failed to protect 1 of 3 sampled residents who required extensive two person physical assistance for bed mobility and transfer. The resident obtained a head injury, skin tears and left femoral fracture. The left femoral fracture required surgical intervention. The resident died after administration of anesthesia. (Resident #1) Findings include: Resident #1 was admitted to the facility on 7/21/2010 with diagnoses of dementia, congestive heart failure, coronary artery disease, mitral valve insufficiency, right sided hemiplegia, hypertension, osteopenia, and rheumatoid arthritis. The resident had a history of coronary	F 323	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: S. Daniel Jew, J. | TITLE: ADMINISTRATOR | (X6) DATE: 4/11/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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graft bypass, surgical repair of a hip fracture, and bilateral knee replacements.

Resident #1 was assessed by the facility on the annual Minimum Data Set (MDS) dated 8/22/12 as being severely impaired in cognitive skills for daily decision making. The MDS revealed the resident required two person assistance for transfer and for bed mobility. Resident #1 was dependent on staff for all areas of daily care, was non ambulatory, and needed one person assistance for bathing and dressing. The resident was coded as having one sided impairment for range of motion due to residual effects of an old stroke. The MDS indicated the resident had not fallen since admission to the facility.

A review of the resident's Care Area Assessment (CAA) on 9/28/12 showed the resident was at risk for falls due to the need for staff assistance with transfers and possible side effects of psychotropic medication use. The resident was on the anti anxiety and anti depression medications Ativan and Lexapro. A review of nursing notes revealed the resident yelled out, especially at night, and became agitated at times. The CAA showed the resident was at risk for skin tears due to fragile skin and a history of recurrent skin tears.

A review of the resident's care plan updated on 8/24/12 showed the resident was care planned as a fall risk. Interventions included the use of a mechanical lift for transfers.

During an interview with the Director of Nursing on 10/2/12 at 11:50 AM she revealed residents

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did not have individual care guides to communicate their needs to Nursing Assistants (NA). She stated Nursing Assistants had access to each resident's care plan kept at the hall nursing station.

A review of the facility staffing for dates 9/18/12, 9/19/12, and 9/20/12 revealed full staffing for Resident #1's hall during first shift. Two nurses and 2 NAs were regularly assigned daily to the resident's area of the hall.

The facility investigation report dated 9/25/12 showed that on 9/19/12 at 6: 20 AM Nurse # entered the resident's room to administer the morning medication. Nursing Assistant (NA) #1 and NA#2 were observed providing incontinent care to the resident. The resident was wearing her gown and an adult brief. The resident had one skin tear on her right hand that was bandaged and was being treated by staff. The over the bed light was on and the nurse administered the medication to the resident. No bruising to the face, no skin tears on the left arm, and no injury to the left lower leg were observed by staff. Staff stated the resident was in bed during the entire 11 PM to 7 AM shift on 9/18 - 9/19/12.

The facility report revealed at 7:00 AM NA #3 assumed care of Resident #1. The report stated NA #3 gave the resident a bed bath and provided AM care. The NA reported to Nurse #2 at 7:45 AM the resident was bleeding through band-Aids on a skin tear site on the left upper arm and had a bruise over the left eye. Nurse #2 entered the room and observed a bleeding skin tear covered with two band-Aids. The nurse dressed the skin

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tear and left the room stating the bruise over the left eye looked old and she would look for an incident report. NA #3 approached Nurse #2, 15 to 20 minutes later and reported the bruise over the left eye was swelling and was now open and bleeding. Nurse #2 entered the resident's room, applied pressure to the hematoma that had developed over the left eyebrow for approximately 5 minutes, applied 2 x 2 gauze, a tegaderm, and a dressing. Nurse #2 stated during the investigation NA #3 requested she document the injuries were present before the 7:00 AM shift began. The Nurse stated she did a neurological assessment but there was no documentation in the resident ' s record. Resident #1 did not get up during the 7AM - 3 PM shift on 9/19/12. NA #3 stated Nurse #2 told her to let the resident stay in bed. The NA reported she provided incontinent care to Resident #1 once more on her shift.

The facility report showed that on 9/19/12 at 3:00 PM NA #4 assumed care of Resident #1. NA #4 stated NA #3 reported to her the resident had not been out of bed during her shift. NA #4 revealed she did her first rounds and observed Resident #1 sleeping and wearing regular clothes. NA #4 returned to Resident #1's room at 5:11 PM to provide incontinent care and to prepare the resident for bed. The NA stated the resident had on tennis shoes, was fully dressed, and had a pillow under both knees. The NA pulled the resident's pants down and noticed "something was not right" with the left lower leg. NA #4 immediately reported the bruise and injury to Nurse #2. The nurse assessed the lower left leg, had vital signs taken, and placed a call to resident's MD. Orders were received from the Physician Assistant (PA), the left knee was

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immobilized, and Resident #1 was transported via Emergency Medical Service (EMS) to a local Emergency Department.

The facility investigation revealed Nurse #2 completed an incident report on 9/20/2012 at 9:58 AM. No injuries for Resident #1 were reported to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) on 9/19/12 until NA #4 discovered the left leg injury on second shift.

The facility investigation report stated: "In conclusion, no one was able to identify exactly what occurred during the investigation. However, due to prior evening and night shift statements confirmed by 4 different employees, it is felt that the injuries occurred on 7 - 3 shift."

A review of Resident #1's hospital records dated 9/19/2012 - 9/20/12 revealed the resident arrived at the emergency department via EMS on 9/19/12 at 7: 30 PM. The resident was assessed and diagnosed with left femur fracture, skin tear at left elbow, head injury, and skin tear of left eyebrow. The resident was admitted for surgical repair of the left leg. The resident had surgery on 9/20/12 for repair of the left femur fracture. During administration of anesthesia Resident #1's blood pressure began to drop. Medications and chest compressions were initiated and the resident stabilized. The surgical repair was canceled and medical staff attempted to do an external fixator to stabilize the leg. The resident again went into cardiac arrest, a code was continued for 30 minutes, and the resident was pronounced dead in the operating room.

An interview was conducted with the DON on

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F 323	Continued From page 5 9/28/12 at 2:20 PM. She stated she had completed the facility investigation into Resident #1's injury and it was considered an injury of unknown origin. She stated interviews with staff on three different shifts established the injury probably occurred on first shift the morning of 9/19/12 between 7:00 AM and 8:00 AM. The DON stated there was only one staff member who was known to have been in the resident's room during this time period. However, the staff member denied she dropped or witnessed the resident fall. The DON revealed the NA denied she put band aides on the left upper arm skin tear. The NA told the DON she did not have access to band aides. The DON stated the band aides were kept in the supply room and all nursing staff had access to the room. The DON stated the facility reported the incident in a 24 hour and 5 day report to the Department of Health and Human Services and to the Wilmington Police as an injury of unknown origin. She indicated the facility had taken disciplinary action against Nurse #2 and NA #3 and had taken corrective steps in the facility to insure resident safety. During an interview on 10/1/12 at 4:10 PM Nurse #1 stated she was assigned to Resident #1 on the 11 PM to 7:00 AM shift on 9/18/12 - 9/19/12. The nurse reported she did not get any report of injuries for Resident #1 during change of shift report. She revealed she made rounds at 1:00 AM and visualized the resident in her bed. The resident had shifted on the bed and both feet were hanging off the side of the bed below the ½ rail. Nurse #1 indicated the resident was often agitated at night and she spent about 5 minutes in the room repositioning and settling the resident	F 323		

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in for the night. Nurse #1 stated the resident could shift off her pillow and lay at a diagonal on the bed with her feet slightly off the mattress on one side. She revealed the resident did not have the mobility to roll or turn herself. The nurse stated she signed out Resident #1's 6:00 AM scheduled narcotic and took it down to her room at 6:15 AM. Nurse #1 stated the resident was on a Fentanyl Patch and Vicodin for rheumatoid arthritis pain. The resident had a fentanyl patch applied to her skin every 72 hours and received a scheduled does of Vicodin at 6:00 AM, 2:00 PM, and 8:00 PM daily. Nurse #1 reported she observed NA #1 and NA #2 providing incontinent care to the resident. She revealed the light over the bed was on and she could see the resident clearly. The nurse stated the resident was wearing a hospital gown and an adult brief, The nurse reported she did not see any bruises on the resident and the only wound on the resident was an old skin tear on the right hand that was bandaged. The nurse indicated during incontinent care the resident was shifted to both sides by the NAs and there were no obvious leg injuries. Nurse #1 revealed she had never seen Resident #1 roll over or turn over independently. She stated one person was usually adequate for care. The Nurse reported she had provided care for the resident by herself and had observed the NA do incontinent care and transfer the resident with no assistance. The nurse indicated the resident did not resist care.

A telephone interview was conducted with NA #2 on 10/2/12 at 8:20 AM.
The NA stated she was orienting with NA #1 on the 11 PM to 7 AM shift on 9/18/12 - 9/19/12 and was assigned to Resident #1. NA #2 revealed

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bleeding under some band-aids on the left upper arm. She stated the resident was half dressed with her right arm in the sleeve of a pull over top and her left arm was out. The nurse reported she cleaned the skin tear and applied a dressing to the site. She indicated she helped NA #3 finish dressing the resident by assisting in getting the left arm in the left sleeve. Nurse #2 revealed she noticed a bruise over the resident's left eye. The nurse stated the NA told her both injuries were old. Nurse #2 revealed NA #3 asked her to document the injuries were old and were present when their first shift began so no one would think they occurred while they were working. The nurse stated the NA approached her about 20 minutes later and told her the bruise over the resident ' s left eye was bleeding. The nurse went to the room, applied pressure for about 5 minutes, and dressed the wound. Nurse #2 stated she asked NA #3 what happened to the resident. She reported NA #3 told her she had given the resident a bath and she did not know how the bruise and skin tear happened. The nurse stated the NA told her the areas were old. The nurse stated she only assessed the resident's head and left arm because the NA only reported those areas. The nurse asked the Physical Assistant (PA) to look at the resident's head wound. The PA saw the resident and documented the bleeding had stopped. Nurse #2 continued the interview by stating there was not a computer available to do an incident report and her day was very busy. The nurse revealed the second shift NA came to her about 6:00 PM and reported the resident had an injury to her left leg. Nurse #2 stated NA #4 told her that when she removed the covers and pants from Resident #1 she observed an obvious deformity of the left leg.

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she mostly observed care during her shift because it was only her third night in the facility and she was orienting. She indicated when the first incontinent care was completed on Resident #1 she watched NA #1 do it. The NA reported the resident was in the bed their entire shift. She stated they never lifted or transferred Resident #1. NA #2 stated she assisted NA #1 in providing incontinent care to Resident #1 about 6:15 AM. She indicated Resident #1 was the last resident they changed on their shift. The NA stated the resident was dressed in a hospital gown and wore an adult brief. She revealed she did not see any bruises or injuries other than an old dark bandaged skin tear on the right hand during care on her shift.

NA #1 was interviewed on 10/2/12 at 10:19 AM. She stated she was assigned to Resident #1 during the 11 PM -7 AM shift on 9/18/12 - 9/12/12. NA #1 revealed Resident #1 had ½ side rails in place. She stated it sometimes took two people to care for Resident #1 and the assigned nurse would help her. NA #1 indicated NA #2 mostly observed during their shift because she was a brand new NA and had just started her orientation. The NA stated the resident was wearing a hospital gown and brief when they did her last incontinent care. NA #1 stated the resident did not have any injuries other than a skin tear on her right hand when her shift ended at 7:00 AM.

During a telephone interview with Nurse #2 on 10/2/12 at 9:20 AM she stated she worked first shift from 7AM to 7 PM on 9/19/12. She stated NA #3 called her into Resident #1's room about 7:14 AM. The nurse revealed the resident was

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The nurse stated she immediately assessed the resident, notified the MD, called EMS when she received the order from the PA, and helped get the resident ready for transport to the emergency room

Nurse #2 indicated the resident's lift pad was in the laundry that morning. She reported the facility did not have enough lift pads and residents had to share.

A telephone interview was conducted with NA #3 on 10/2/12 at 10:45 AM. The NA stated her usual schedule for Resident #1 was to get the resident washed, dressed, and up for the day before trays arrived on the hall. NA #3 reported she first saw Resident #1 about 7:20 AM. She revealed she gave the resident a bed bath, checked the brief, and attempted to change the resident from the hospital gown to regular street clothes. The NA indicated she put the resident's shirt on the right arm and then noticed a skin tear covered with band aides that was bleeding on the left arm. The NA stated she then saw a "bump" on the resident's head. NA #3 revealed she went to Nurse #2 who was assigned to the resident. The NA reported the nurse put a dressing on the skin tear and the NA then pointed out the bump on the resident's head to the nurse. The NA first stated she put on the resident's shoes because the resident usually got up for the day. Later in the interview NA #3 stated she put on the shoes to protect the resident's heels. The NA stated the resident did not have a pillow to float her heels on the bed to prevent pressure so she put her shoes on. NA #3 revealed 30 minutes later she brought in the resident's breakfast tray and noticed the head bruise was now bleeding and swollen. The

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F 323	Continued From page 10 NA stated she went and got Nurse #2 again and reported the bleeding. She stated the nurse treated the resident and the bleeding stopped. NA #3 reported she fed the resident, checked for incontinent care, and returned at lunchtime to feed the resident again. The NA revealed the nurse told her to let the resident stay in bed because she was drowsy. NA #3 denied she attempted to get the resident out of bed the morning of 9/19/12. The NA stated she could not get the resident up because she was waiting on a yellow pad (small size) for the mechanical lift to transfer the resident. She stated staff had to wait for lift pads sometimes to transfer residents. NA #3 stated staff were to always have 2 people when they used a mechanical lift and she stated she always had a partner. NA #3 stated during the interview, "I did not hurt this lady". An interview was conducted with NA #4 on 10/1/12 at 4:35 PM. The NA stated she was assigned to Resident #1 for the second shift (3 PM - 11 PM) on 9/19/12. NA #4 revealed that NA#3 reported off to her at the beginning of the shift. She stated NA #3 told her she had not gotten the resident out of bed during her shift on instructions from the nurse because the resident was drowsy. NA #4 stated NA #3 suggested that she not get the resident up during second shift. NA #3 reported off that she had just changed the resident. NA #4 stated she checked on Resident #1 during her first rounds. She observed the resident in bed dressed in regular clothing. The NA stated she was on dining hall duty so she asked NA # 5 to feed the resident while she worked in the dining room. Upon her return to the floor NA #4 went into Resident #1's room to provide incontinent care and get the resident	F 323		

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ready for bed. NA #4 revealed when she pulled the covers down the resident was wearing tennis shoes and had a pillow under her knees. The NA stated she got angry because she could not understand why the resident had been left in bed all day with shoes on and why the pillow was under the resident's knees. NA #4 stated the resident was on an air mattress and a pillow was not needed to relieve pressure. The NA pulled off Resident #1's pants and immediately observed the left knee was turned in and had a large red spot. The NA stated she could see the bone sticking up in the skin but it was not all the way through. NA #4 stated between the bruise, the skin tear, and the leg the resident looked beat up. The NA reported the resident had ½ rails on her bed. She indicated the resident was total care and moved very little except to move off the pillow and move her feet off the bed. The NA stated staff would reposition the resident by realigning her with the pillow. The NA revealed the resident could not move enough to hurt herself against the rails or move off the bed. She stated the resident was moved with a mechanical lift.

An interview was conducted with NA #5 on 10/1/12 at 5:00 PM. She stated that she worked the 3 PM to 11 PM shift on 9/19/12 and helped feed Resident #1. The NA stated she had cared for the resident many times and was very familiar with her. NA #5 revealed on 9/19/12 the resident was unusually quiet and would not eat her supper. NA#5 stated she had cared for the resident on 9/18/12 and had not observed any injuries other than the skin tear on the right hand. The NA revealed she was very surprised when she saw the bandage over the resident's eye and on the resident's left arm on 9/19/12. NA #5

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stated she asked Nurse #2 what had happened to the resident and the nurse replied she did not know.

An interview was conducted on 10/2/12 at 2:10 PM with the Physician Assistant (PA) who saw Resident #1 on 9/19/12. The PA stated Nurse #2 asked her to look at the resident's head. The PA reported she examined the resident and was told by NA #3 it was not a new injury. She indicated the resident was being fed by NA #3 and appeared to be fine.

A review of the PA's documentation in the chart on 9/19/12 at 8:50 AM revealed she saw the resident secondary to a hematoma on the left side of the left eyebrow. The PA documented per nursing staff / NA this was not a new hematoma. She made a note of several skin tears to the left arm, documented no signs or symptoms of infection, and wrote no focal deficits. The PA wrote to monitor the resident.

A telephone interview was conducted with the Paramedic who transported Resident #1 from the facility to the emergency room on 10/3/12 at 2:40 PM. The Paramedic reported upon his arrival Resident #1 was nonverbal and lying in bed. He stated when he saw the resident's left leg, bandaged head and left arm; he asked staff if the resident had fallen. He revealed staff told him they did not know how the injuries occurred. He stated staff told him the resident could not walk, could not get out of bed, and no one knew what had happened. The Paramedic said staff reported they found the resident in bed with the leg injury.

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A telephone interview with the Radiologist was conducted on 10/2/12 at 3:08 PM. The Radiologist stated he had reviewed Resident #1's X ray and he remembered the fracture. He revealed it was his opinion the mechanism of injury was most likely from a fall given the severity and type of fracture. He indicated the fracture was acute because the bone showed no signed of healing.

Resident #1's primary doctor was interviewed on 10/2/12 at 5:22 PM. The doctor stated she saw Resident #1 in the hospital on the morning of 9/20/12 to evaluate for surgical clearance. The MD reported the resident had multiple medical conditions that made the surgery high risk but the leg needed to be repaired. The MD revealed she had thought a long time about what happened to the resident in the facility. She stated, "I think the resident may have fallen. The leg could have been injured then and as the day progressed the resident moved about in bed and caused the dislocation and protrusion of the bone. I can not explain the hematoma or the skin tear unless the resident hit something or was injured in a fall." The physician stated she believed the hematoma, skin tears, and leg fractures were new injuries due to their appearance.

The emergency room Physician who first assessed Resident #1 at the hospital was interviewed by telephone on 10/6/12 at 2:15 PM. He stated the Paramedic reported to him the resident was found in her bed with the leg injury. He stated the leg had an obvious deformity with the bone all but protruding through the skin. He revealed the Paramedic informed him facility staff did not know how the injury occurred. He stated

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with the head injury, arm lacerations, and the fractured leg he believed the resident probably sustained a fall at some point during the day. The Physician stated the skin at the site where the bone was pressing upward had turned red and was beginning to break down. He stated the injury was new, acute, and most likely occurred that day.

On 9/20/12 the facility initiated steps to ensure the residents were safe from a similar injury. The facility submitted a 24 hour initial report to the state and notified the Wilmington Police department of the incident. Nurse #2 and Nursing Assistant #3 were suspended pending outcome of the facility investigation.

An in-service was initiated by the Staff Development Coordinator for all full and part time Nursing Assistants on 9/20/12. The in-service included:

- How to use a lift or stand assist device for transfer
- Always check care plan at beginning of shift to know what assigned resident will require
- Inform supervisor or charge nurse if you cannot locate a device or sling your resident requires
- Never attempt to move or transfer a resident without proper care planned device The sling size and type of device will be located inside the resident ' s closet door
- If you identify an injury notify your nurse immediately. It you do not think the the nurse assessed the resident then contact the DON
- report an injuries that occur while you are

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F 323	Continued From page 15 providing care All Nursing Assistants were to be in-serviced prior to 9/27/12. Staff who had not had the in-service would not be allowed to work until it was completed. An in-service was initiated for all nursing staff on 9/20/12. Staff were to be in-serviced on how to assess residents after information was presented to them by other staff or family members. Nurses were to fully assess the resident and document any changes per facility policy. Staff Development and the DON went over how to contact the MD, notify the family, how to assess residents for a change in condition, and how to report to the DON if they feel another nurse has not properly assessed her patient. All staff were to be in-serviced prior to 9/27/12. Staff who had not had the in-service would not be allowed to work until the in-service was completed. On 9/21/12 an in-service was presented to the NAs who worked at the facility on abuse. The in-service addressed the types of abuse and the types of injuries that should be reported immediately to the nurse. Staff were required to complete the in-service by 9/27/12. NAs would not be allowed to work until the in-service had been completed. The Assistant Director of Nursing (ADON) assessed each resident in the facility for the need of a mechanical lift on 9/21/12. Results of the audit were compared to each resident ' s care plan by MDS staff to ensure any resident who required a lift had the interventions present. Care guides were checked to ensure resident information was correct. Each resident requiring	F 323		

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F 323	Continued From page 16 a mechanical lift (41 residents) was sized for the appropriate lift pad. The color of the lift pad indicated the size of the sling. The lift pad size was posted on a color coordinated card inside the closet door for each resident requiring use of a mechanical lift for transfer. The facility was in the process of buying individual pads for each resident so staff would have a pad available at all times to use with the mechanical lift. The Quality Assurance (QA) team developed an audit tool for mechanical lifts on 9/22/12. The audit tool was developed to monitor staff compliance with mechanical lift policy and identification and documentation of skin tears. The audit was initiated for the week of 9/24/12 - 9/28/12. Five residents were to be observed during a transfer by a NA. Designated staff were to visualize the transfer, check skin for any signs of abuse, and review charts and care plans. Interviews were to be conducted with NAs and nurses on different shifts about abuse or concerns with other co workers not taking care of residents. Five resident records were to be reviewed to see if skin tears or injuries were documented and treated. The QA team looked to see if any injuries of unknown origin occurred and were they reported to the DON. This audit was to be done by 2 designated staff weekly x 3 months or until QA considered the matter resolved. A second audit tool was developed by the QA team on 9/22/12 to monitor change of condition. The audit tool was to monitor change of condition in residents to see if it was noted, documented, the MD was notified, the MD responded, and if the Medical Director or Supervisor on call was	F 323		

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F 323	Continued From page 17 notified if needed. The audit was initiated for the week of 9/24-12 - 9/28/12. The audit was to be done weekly by designated staff x 3 months or until the QA team considered the matter resolved. On 9/26/12 the facility submitted to the state a 5 day report with the facility investigation attached. NA #3 and Nurse #2 were terminated by the facility due to resident safety concerns and failure to report and assess an injury. The facility reported the NA and nurse to the appropriate state agencies. Attendance records for the 3 initiated in-services were reviewed. All staff working at the facility completed the training. A review of the audit tools initiated to monitor compliance of staff to the in-services indicated nursing and direct care employees were following facility policy for safe transfers, identification and documentation of injuries, and for assessment and follow through on changes in condition. An initial tour was conducted at the facility on 9/28/12 at 10:40 AM. Residents in their beds were observed to have active bed alarms, padded mats on the flour beside the bed and raised side rails as care plans indicated. Throughout the investigation direct care staff were observed working in teams of two when they transferred residents with mechanical lifts.	F 323		