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F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (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. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews, the facility failed to safely provide a bed bath for 1 of 3 sample residents (Resident #2) reviewed for accidents. This occurred when the resident fell from her bed while one staff member was giving her a bed bath, resulting in the resident sustaining fractures of both her right and left femurs (the long bone of each leg). The findings included:	F 323	1. The maintenance department replaced the bed and mattress for affected resident with bariatric bed and mattress on 6/19/17. The MDS Coordinator updated the care plan on 6/27/17 to reflect two person assist for bed mobility. 2. DON, ADON, and Nursing Unit Managers collectively conducted an initial audit for all residents to determine the	10/20/17

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

Electronically Signed | 10/11/2017

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F 323	Continued From page 1 Resident #2 was initially admitted to the facility on 4/29/16 from the community. A review of the resident ' s most recent annual Minimum Data Set (MDS) dated 5/5/17 indicated Resident #2 had intact cognitive skills for daily decision making. She was assessed to have moderate difficulty with hearing. No behaviors nor rejection of care were reported. The MDS assessment indicated Resident #2 required extensive assistance from two or more staff members for bed mobility and transfers. The resident required extensive assistance of one for locomotion on the unit, dressing, toileting, and personal hygiene; she was totally dependent on staff with assist of one for locomotion off the unit and for bathing. Resident #2 was independent with eating, but required assistance with meal set-up. Resident #2 had a functional limitation in the range of motion of her lower extremities (both sides). She utilized a wheelchair for mobility. Section J of the MDS assessment revealed the resident did not have any falls since her prior assessment. Section K reported Resident #2 was 60 inches tall and weighed 235 pounds (#). A review of the Care Area Assessment (CAA) Summary Reports for Activities of Daily Living (ADLs)/Rehabilitation Potential (dated 5/17/17) and Falls (dated 5/17/17) indicated the resident required staff assistance with ADLs (Activities of Daily Living) and mobility. She was non-ambulatory at the time of the review; staff assisted her with mobility on and off of the unit. No falls were noted. The CAA indicated a care plan would be developed for each of these care areas. The plan of care for Resident #2 included an area	F 323	residents who meet bariatric criteria on 10/17/17. All residents who were deemed bariatric from our initial audit were provided a bariatric bed and mattress. Preadmission screening will be completed by DON and/or ADON to determine if a special sized bed is needed, and if so, the bed will be obtained prior to admission. Also, the DON, ADON, and/or Nursing Unit Managers will assess all residents no later than one business day after admission to ensure that their bed is of appropriate size and will make adjustments if necessary. DON, ADON, and Nursing Unit Managers collectively conducted an audit on 10/17/17 for all residents for the need of two person assist regarding bed mobility and updated care plans accordingly for those affected. Preadmission screening will be completed by DON and/or ADON to determine whether a potential resident requires a 2 person assist regarding bed mobility. Each potential admission that is deemed appropriate for 2 person assist for bed mobility will be added to our “Bed Mobility Assistance tool” that will be located at each nursing station showing all residents that are in need of 2 person assistance for bed mobility. DON, ADON, and/or Nursing Unit Managers will assess each new admission no later than one business day after admission for the need of 2 person assistance regarding bed mobility and update the “Bed Mobility Assistance tool” if necessary. The “Bed Mobility Assistance tool” will be located at each nursing station and will be updated as needed to address new admissions. This tool will	

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F 323	Continued From page 2 of focus related to ADL Functional/Rehabilitation Potential (initiated 3/22/17): The resident required assistance with ADLs and mobility related to Alzheimer ' s disease, hypothyroidism, diabetes, convulsions, Vitamin D deficiency, anemia, and gastro-esophageal reflux disease. Approaches (interventions) listed for this area of focus were: --Explain procedure and why prior to attempt (Approach Start Date 3/22/17); --Monitor for presence of pain/intolerance during self-care. Provide pain medications as ordered. Monitor for effective response (Approach Start Date 3/22/17); --Provide adequate rest periods between activities (Approach Start Date 3/22/17); --Provide assistance for ADLs and mobility as needed (Approach Start Date 3/22/17); --Provide verbal cues and reminders for safety as needed (Approach Start Date 3/22/17); --Report any further deterioration in status to physician (Approach Start Date 3/22/17). Resident #2 ' s plan of care also included an area of focus related to Falls (initiated 3/22/17): The resident was at risk for falls due to weakness/impaired balance and decreased mobility related to chronic osteoarthritis pain in bilateral lower extremities. Resident was non-ambulatory. Resident also had dementia and received anti-seizure medications which may have further increased fall risk. Approaches (interventions) listed for this area of focus included: --Administer pain medications as ordered. Monitor for effective response and for side effects (Approach Start Date 3/22/17); --Assist with toileting and incontinence care as needed (Approach Start Date 3/22/17);	F 323	also be updated weekly to address our current resident's changing needs. DON, ADON, and/or Nursing Unit Managers will be responsible for updating this tool. The "Bed Mobility Assistance tool" will be implemented and placed on each nursing station by 10/20/17. 3. DON, ADON, and Unit Managers will collectively educate all staff on bed mobility, bathing, hearing, and adhering to the needed level of assistance relating to bed mobility and bathing by 10/20/17. Any staff not available by 10/20/17 will be in-serviced before the start of their next shift. 4. DON, ADON, Unit Managers and/or Licensed Nurses will monitor 12 nursing assistants providing bed mobility and bathing per audit. Audits will be conducted weekly for one month, then bi-weekly for two months, then monthly for three months. Audits will be conducted on all shifts, including weekends. All results will be reported in our monthly QAPI meeting. Also, DON/ADON/Unit Managers will report on the previous month's admissions in our monthly QAPI meeting and ensure that the appropriate size bed was obtained for each resident.	

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--Increased staff supervision with intensity based on resident need. Place call bell and personal items within reach
(Approach Start Date 3/22/17).

A review of a Fall Huddle report dated 6/18/17 at 12:15 PM described an incident involving Resident #2 when she "slid off the bed." The team summary noted, "During her bath, [name of the Nursing Assistant or NA] had her laying over on her (left) side to wash her bottom. When done, she asked [name of Resident #2] to turn back over onto her back, but [name of Resident #2] turned further to the (left) and slid off the bed onto her knees." The Action Plan read, "Speak loudly into [name of Resident #2] ear when speaking to her due to her being HOH (hard of hearing)."

A review of the resident ' s medical record included a Nursing Note dated 6/18/17 at 4:32 PM. The note reported: "Resident slid off her bed onto her knees during her bath. She was gotten up using the [brand name] lift (a mechanical lift). She sustained a skin tear on her R (right) forearm and c/o (complained of) both knees hurting. No bruising/swelling noted. Resident ' s (family member) made aware, nursing supervisor made aware and [name of on-call physician] ordered an x-ray of both knees and to observe her."

Further review of the resident ' s medical record included an x-ray report dated 6/18/17 at 6:31 PM. The report included an impression of the left knee indicating there was an acute distal femur fracture. The report also noted x-rays indicated the resident had a possible non-displaced fracture involving the distal right femur.

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A Nursing Note dated 6/19/17 at 3:22 AM indicated the x-ray reports of the resident ' s left and right knees were faxed to the resident ' s physician. Another Nursing Note dated 6/19/17 at 12:34 PM revealed the facility ' s Nurse Practitioner (NP) instructed the facility to send the resident out to the Emergency Department. The resident left the facility via an Emergency Medical Service at 12:15 PM.

A review of the hospital records included x-ray reports dated 6/19/17. The reports indicated Resident #2 had a mildly displaced metaphyseal fracture (also known as a corner fracture) of her distal right femur (the end of the long bone of the right leg down by the knee). She also had a displaced mild impacted minimal comminuted fracture (indicating the bone was broken into pieces) of the distal left femoral metaphysis (the end of the long bone of the left leg down by the knee).

Further review of Resident #2 ' s hospital records included the Emergency Department Provider Notes. The notes indicated Resident #2 was evaluated in the Emergency Department. She was placed in splints and it was determined non-operative management was appropriate since the resident was already non-weight bearing and non-ambulatory. Her family was reported as comfortable with the plan for pain management.

Resident #2 returned to the facility on 6/19/17 at 10:30 PM.

A review of the resident ' s medical record included a Nursing Note dated 6/23/17 at 3:46 AM. The notation revealed Resident #2 was

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resting on a new Bariatric bed with an air mattress.

A review of the resident ' s medical record also revealed a Hospice referral was made on 6/24/17. Resident #2 was admitted to Hospice Care on 6/27/17 with a diagnosis of acute respiratory failure, unspecified, with hypoxia (a low level of oxygen in the blood or tissues) or hypercapnia (abnormally high carbon dioxide in the blood).

A Fall Risk Assessment was completed for Resident #2 on 6/29/17. Her total Fall Risk score was = 17.0, indicating the resident was at risk for falls. A notation was made on the fall risk assessment to continue the current plan of care.

On 6/30/17, an MDS assessment was completed due to a significant change noted for Resident #2. This assessment revealed the resident was assessed by staff as having modified independence in regards to her cognitive skills for daily decision-making. No behaviors nor rejection of care were reported. The MDS assessment indicated Resident #2 required extensive assistance from two or more staff members for bed mobility, dressing, toileting, and personal hygiene. She was totally dependent on staff for transfers and locomotion on/off the unit with assistance of one, and bathing with assistance of two or more staff members. The resident required supervision with eating and the assistance of one staff member. The MDS indicated Resident #2 had a functional limitation in the range of motion of her lower extremities (both sides) and she utilized a wheelchair for mobility. Section J of the MDS assessment revealed the resident had one fall with a major

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injury since her prior assessment. The resident ' s assessment revealed she had a condition that may result in a life expectancy of less than 6 months. The MDS also indicated Resident #2 was receiving Hospice care.

A review of the resident ' s Care Area Assessment (CAA) Summary Reports for ADLs / Rehabilitation Potential (dated 7/6/17) reported the following, in part: "Resident requires increased staff assistance with ADLs due to recent fall from her bed during bathing task ...She has bilateral leg splints in place. [Brand name] catheter inserted prior to this review due to prolonged immobility and comfort. Resident requires incontinence care and hygiene by staff due to stool incontinence." A review of the resident ' s Care Area Assessment (CAA) Summary Reports for Falls (dated 7/6/17) also reported the "Resident requires increased staff assistance with ADL ' s due to recent fall from her bed during bathing task with staff. No other recent falls noted."

Resident #2 ' s care plan for ADL Functional / Rehabilitation Potential was revised on 9/26/17 to include, "Update: bilateral femur fractures s/p (status post) fall." The care plan interventions for this care area were not revised. Resident #2 ' s care plan interventions related to Falls were updated on 6/27/17 and 9/26/17 to include the following:
--"Place bed in low position when care is complete" (Approach Start Date 9/26/17);
--"Reposition as needed with 2 assist for comfort" (Approach Start Date 9/26/17);
--"Bed mobility/turning assist of 2 staff" (Approach Start Date 6/27/17).
Resident #2 ' s care plan also included an area of

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focus related to Hospice (Problem Start Date 6/29/17): "Resident is on Hospice Care related to end of life care."

A review of the resident ' s medical record included a Nursing Note dated 9/26/17 at 11:04 AM which read, in part:
" ...Bedfast d/t (due to) femur fractures ...Staff unable to get weight on resident since femur fracture injuries in 6/2017, but visibly has lost weight (face thin, sunken in). Res. (Resident) Noted with significant decline last few months. Remains on hospice care d/t condition. Will continue to monitor."

An observation was conducted on 9/26/17 at 12:20 PM of Resident #2 as she was lying in bed asleep. The resident ' s bed was identified as a bariatric bed with an air mattress in place. She appeared to be resting comfortably.

An interview was conducted on 9/27/17 at 11:43 AM with the facility ' s Assistant Director of Nursing (ADON). Upon inquiry regarding Resident #2 ' s fall on 6/18/17, the ADON reported one NA who had bathed the resident many times before gave the resident a bed bath. The NA raised the bed for the bed bath. While giving Resident #2 her bed bath, the NA turned the resident over onto her side and positioned the resident ' s leg over her without realizing how close she was to the edge of the bed. When the NA instructed the resident to roll back, the resident rolled forward instead. The ADON noted Resident #2 was hard of hearing. She reported there was an investigation from Risk Management in regards to this fall and safety interventions were put into place. The ADON reported the resident ' s bed was replaced with a

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bariatric bed. She explained the regular-sized bed was "not appropriate" for the resident because of her wide girth. The ADON also stated the facility put into place a "2-person assist" for the provision of Resident #2 ' s care. The facility did a "house-wide sweep" and replaced two more residents ' beds with bariatric beds. Additionally, the staff was educated on communicating with and taking care of residents who were hard of hearing. The ADON reported fall audits (consisting of the numbers and injuries) has been a part of the facility ' s usual Quality Assessment and Assurance (QAA) process.

Accompanied by the ADON, an observation was made on 9/27/17 at 11:50 AM of Resident #2 as she was lying in her bed with a visitor by her side. A bariatric bed was observed to be used for the resident with an air mattress in place. The resident was sleeping soundly; she appeared to be resting comfortably.

An interview was conducted on 9/27/17 at 12:07 PM with the facility ' s Administrator. During the interview, the Administrator was asked if a Quality Assessment and Assurance (QAA) plan had been developed to monitor any new systems put into place to ensure residents ' safety during the provision of ADL care. The Administrator indicated the issue of falls was already a component of the QAA meetings where the number of falls were discussed. However, the Administrator reported he was new to the position (started June 2017) and had only been involved in one QAA meeting to date.

A follow-up interview was conducted on 9/27/17 at 1:30 PM with the ADON. The ADON provided a copy of the written in-service education given to

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the nursing staff (dated 7/11/17). She explained the written information was put in a Communication Book kept at each of the five nursing stations. Nursing staff were asked to sign an Education Attendance Record upon review of the written information. When asked if all nursing staff had received the education, the ADON stated she was not sure.

A review of the in-service education dated 7/11/17 revealed training consisted of two main topics:
(1) "Obese Resident: Charge Nurse and Nurse Techs our current beds can hold a certain amount of weight, however, we have found that depending on how our resident ' s weight is distributed, our beds have been found to not be safe. So going forward:
*Charge Nurses when getting report for your new admission, obtain HT (height) and Weight. This will give us a chance to review proper bed side. If you have concerns notify [name and phone number of ADON].
*Review the fit/size of all current resident to ensure proper bed size beds. We need to ensure that the resident can be safely turned and ADL ' s performed when in bed. Do we need a bariatric bed? Notify [name and phone number of ADON] ASAP (as soon as possible) if you have any concerns about a resident ' s bed size and/or safety.
*We encourage the use of 2 staff members when caring for the obese resident. This for the resident ' s safety as well as yours."
(2) "When Caring for the Hard of Hearing Resident:
1. Realize that you don ' t have to SHOUT! Shouting actually makes communication harder to understand. It can also be somewhat intimidating, and embarrassing.

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2. Deliver your message face-to-face, rather than from across the room or from the next room. We all use lip-reading to some extent to help us hear.
3. Eliminate background noise, Turn off the TV or radio. Even the low hum of the dishwasher or a leaf blower outside can muffle your words.
4. Don ' t rely on hearing aids working perfectly. If you find that someone with a hearing aid is having trouble hearing well or isn ' t using it, ask questions to find out why. Is it uncomfortable? Is ambient sound interfering?
5. Especially with someone who has dementia, avoid talking while coming up from behind him or her. You may not be heard until you ' re right upon the person, causing your loved one to be started and flustered-and not comprehend a word you ' ve said.
6. If the person has vision problems, know what his or (her) range of vision is. For some people, there ' s little peripheral vision (on the sides), so you must be positioned squarely in front to be seen and understood. This information can be obtain from eye MD (Medical Doctor).
7. Speak slowly and clearly. You don ' t have to dumb down your speech to robot tones, but try not to rush through your sentences, either. You ' ll be more easily heard by any listener, of any age or health condition."

An interview was conducted on 9/27/17 at 1:50 PM with NA #1. NA #1 was identified as the nursing assistant who gave Resident #2 her bed bath at the time of her fall on 6/18/17. During the interview, the NA reported she did not normally take care of Resident #2, but had cared for her in the past. The NA stated when she was giving the resident a bed bath, she assisted her to roll over so the resident ' s back was facing her. After NA #1 had washed the resident, the NA asked the

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resident to roll back towards her. However, Resident #2 rolled forward and the NA stated she could not catch her. NA #1 stated the hall nurse was in the room working with Resident #2 ' s roommate at the time of the fall. NA #1 stated she did not feel comfortable moving the resident, but the nurse decided to use the Hoyer lift to get her up in her chair. After putting her in the chair, they decided to transfer the resident to her bed because she was in pain. NA #1 reported the fall was investigated by the facility and a larger bed was obtained for Resident #2. NA #1 stated she herself no longer worked on Resident #2 ' s hall, but understood staff members were instructed to use a 2-person assist for all of the care provided to this resident. When asked how many residents on her current hall assignment needed to have 2-person assistance, she responded, "at least two (residents)." Upon inquiry as to whether 2-person assistance was utilized when providing care to these residents, the NA stated, "Not always."

A telephone interview was conducted on 9/27/17 at 2:30 PM with Nurse #1. Nurse #1 was identified as the nurse who was assigned to Resident #2 ' s hall on 6/18/17 at the time of her fall. During the interview, Nurse #1 stated she was in Resident #2 ' s room attending to her roommate at the time of the fall. The nurse reported she knew the nursing assistant (NA) was giving Resident #2 a bed bath and the privacy curtain. The nurse reported hearing NA #1 tell the resident, "Okay, come on back over." Nurse #1 recalled a few seconds later she heard the resident scream out in "a hurtful voice." When the nurse got to Resident #2 ' s side of the room, she saw the resident was on her knees on the floor (on the opposite side of the bed from the

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	345091	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE AT THE VILLAGE AT BROOKWOOD	1820 BROOKWOOD AVENUE BURLINGTON, NC 27215

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NA). NA #1 told the nurse that when she told Resident #2 to "come back over," she rolled the other way. At that point, Nurse #1 and NA #1 used a mechanical lift that was already in the room and put her on the bed. The nurse reported the resident was crying and saying her legs hurt "so bad." Nurse #1 stated she did an assessment and checked the resident ' s range of motion. She then called the resident ' s physician, who told her to monitor the resident. After a couple of hours, the nurse stated she called the physician back and got an x-ray ordered. When the nurse left her shift that day, the mobile x-ray report had not yet come back. Upon inquiry, Nurse #1 reported she has worked one time on the resident ' s hallway since her fall. The nurse stated she has not received in-service training related to safety issues for residents since the incident occurred. Nurse #1 reported that she herself made the suggestion that if a resident required a Hoyer lift for transfers, he/she should have two nursing assistants for all incontinence care, bathing, and transfers. When asked if two-person assistance was always provided for residents identified as requiring it, the nurse replied, "No."

An unsuccessful attempt was made to contact Nurse #2 for a telephone interview on 9/27/17 at 4:05 PM. Nurse #2 was typically assigned to work on Resident #2 ' s hall. A voice mail message was left requesting a return phone call.

An interview was conducted on 9/27/17 at 4:15 PM with the facility ' s Director of Nursing (DON). Upon a review of the nursing staff employment list compared to the 7/11/17 Education Attendance Records, the DON confirmed not all staff received the in-service education. A review

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of a list of the facility ' s nursing staff (licensed and unlicensed) indicated there were 84 nursing staff members (54 NAs and 30 nurses) who worked at the facility. The in-service Education Attendance Record (dated 7/11/17) with the subjects of "Obese Resident" and "When Caring for the Hard of Hearing Resident" included the signatures of 21 nursing staff members (12 NAs and 9 nurses) on three separate signature sheets. The DON noted the Administrative staff was unable to locate the signature sheets from two of the five nursing stations.

A follow-up interview was conducted on 9/27/17 at 4:30 PM with the DON. Upon inquiry, the DON confirmed Resident #2 did not have an assessment (including a Fall Assessment) prior to her annual MDS to determine the number of staff required for the safe provision of ADL care. The DON also noted this MDS assessment (dated 5/5/17) indicated the resident required extensive assistance from two or more staff members for bed mobility. The resident was totally dependent on staff with the assistance of one for bathing.

An interview was conducted on 9/27/17 at 4:32 PM with the facility ' s MDS nurse. During the interview, the nurse reported a former MDS nurse (no longer employed by the facility) completed Resident #2 ' s annual MDS assessment dated 5/5/17. The current MDS nurse reported the electronic Point of Care ADL Report was likely used to determine the coding of Section G (ADLs) on the MDS. A review of the ADL report from the facility ' s electronic record revealed the MDS had been coded correctly to reflect the ADL assistance provided to the resident for the 7- day look back period (4/29/17-5/5/17).

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An interview was conducted on 9/27/17 at 2:53 PM with NA #2. During the interview, the NA reported she was very familiar with the residents on the hall, including Resident #2. NA #2 reported Resident #2 was supposed to have the assistance of two staff members for all of her ADL care. When asked if 2-person assistance was always provided for those residents who required it, the NA indicated it was not. The NA reported that sometimes (particularly on weekends) there may be only one NA assigned to a hall, making it very difficult to provide 2-person assistance for residents who required it.

An interview was conducted on 9/27/17 at 5:30 PM with the DON. The Administrator joined the interview on 9/27/17 at 5:35 PM. During the interview, the DON noted was new in her position at the facility and was not on staff when Resident #2 fell (6/18/17). The DON was asked what her expectations would have been in regards to the resident ' s ADL care as it related to the fall on 6/18/17. The DON stated that for the resident ' s care at the time, she thought one NA providing her bath was adequate as there had been nothing like in her history to suspect that (the fall) would have happened. The DON also reported she would have liked to have seen documentation of the in-service education for all 5 nursing stations, along with documentation of monitoring for the interventions implemented after the resident ' s fall.

Multiple attempts were made to interview the resident. However, the resident was very sleepy and unable to be interviewed.

On 9/28/17 at 10:27 AM, Nurse #2 returned the telephone call placed to her on 9/27/17 and a

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telephone interview was conducted. Nurse #2 reported she was not assigned to Resident #2 ' s hall at the time of her fall. However, she stated she was very familiar with the resident (both before and after her fall in June, 2017). During the interview, the nurse was asked what interventions had been put into place to safely provide ADL care for Resident #2 since her fall. Nurse #2 reported the facility reassigned the NA who provided the resident ' s bed bath when she fell to a different hall. Nurse #2 stated, "All of the staff concurs that (the fall) could have been prevented." The nurse explained further by stating there should have been a second nursing assistant helping NA #1 to give the resident a bed bath. She reported any movement of the resident (even before her fall) should have required two staff members. The nurse added, "This is something that should not have happened." When asked how the facility ' s NAs would know how much assistance a resident needed for ADL care (1-person assistance versus 2-person assistance), the nurse stated, "They don ' t know." She reported this type of information was verbally shared from one nursing staff member to another. The nurse added, "You and I both know that ' s not the best way."