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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 09/17/24 through 09/19/24. The following intakes were investigated: NC00217494, NC00217614, NC00218710, NC00221364, NC00221458, NC00221903, and NC00221920. 3 of the 12 complaint allegations resulted in a deficiency. Event ID#5CIN11 . Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G). CFR 483.25 at tag F700 at a scope and severity (G). Noncompliance began on 07/09/24 and the facility came back in compliance effective 08/31/24. The survey team completed the complaint investigtion on 09/19/24. The posting of the 2567 was delayed due a hurricane in the region which greatley impacted internet and communication efforts. The posting was completed on 10/04/24. Event ID: 5CIN11.	F 000		
F 689 SS=G	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.	F 689		

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

Electronically Signed | 10/06/2024

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Nurse Practitioner (NP), Medical Director, family, and staff interviews, the facility failed to prevent an accident when a resident (Resident #1) who received Eliquis (anticoagulant medication) sustained an injury from a bed rail assist bar on 8/30/24. Resident #1's injury from the bed rail assist bar resulted in the formation of a large hematoma, swelling, and diffuse black/purple bruising to her left arm from her left elbow down to her fingertips. The hematoma ruptured resulting in a large open wound to the left upper forearm with fat tissue exposure and uncontrolled bleeding. Resident #1 was transferred to the hospital emergency room on 8/30/24 for treatment of her injury and returned to the facility that evening with a pressure dressing in place to her left arm. On the morning of 8/31/24 Resident #1 had bleeding through the pressure dressing to her left arm that was unable to be controlled and required for her to be transferred back to the hospital emergency room. According to hospital records Resident #1 was admitted to the hospital on 8/31/24 with acute blood loss anemia (not enough healthy red blood cells), bleeding from her wound, and for observation/trend of her hemoglobin. This deficient practice affected 1 of 5 residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 7/9/24 with the following diagnosis: vascular parkinsonism (parkinson symptoms (slow movements, tremor, difficulty walking, stiffness/ rigidity) that are caused by problems with the	F 689	Past noncompliance: no plan of correction required.	

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vessels in the brain), dementia, left sided bell's palsy (a neurological disorder that causes weakness or paralysis of the muscles on one side of the face), macular degeneration (eye disease that causes blurred or reduced central vision), spondylosis (degenerative spine disorder) with radiculopathy (nerve condition that causes pain, weakness, and numbness that can spread into the shoulder, back, and arm) cervical (neck) region, right shoulder osteoarthritis, history of deep vein thrombosis (DVT) (blood clot).

The admission Minimum Data Set (MDS) assessment dated 7/15/24 revealed that Resident #1 had severe cognitive impairment. She was not documented for behaviors or rejection of care. Resident #1 was coded as having impaired vision and upper extremity range of motion impairment on one side. She was also documented on the MDS that she required substantial/ maximum assistance with rolling in bed and transfers.

Resident #1's care plan revealed she had an activity of daily living (ADL) self-care performance deficit care plan revised on 7/17/24. The care plan included the intervention to encourage use of assist bar on the left side of bed to promote bed mobility and positioning. The ADL care plan also had an intervention that read bed mobility: The resident requires substantial maximal assistance by staff to turn and reposition in bed.

There was an additional care plan dated 7/17/24 for anticoagulation therapy. The care plan goal read: Resident #1 will be free from discomfort or adverse reactions related to anticoagulation use. The anticoagulation care plan included to observe/document/report adverse reactions of anticoagulation therapy.

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Resident #1 had a care plan revised on 8/8/24 for potential impairment to skin integrity related to fragile skin. The care plan interventions included to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.

Further review of Resident #1's care plan revealed she also had a care plan dated 7/17/24 for impaired visual function related to Macular Degeneration and left eye decreased movement. The care plan goal was that Resident #1 would maintain optimal quality of life within limitation imposed by visual function. The impaired vision care plan included to observe/document/report any signs/symptoms of acute eye problems.

Resident #1's physician orders revealed an order dated 7/19/24 that read: [brand name assist bar] to left side of bed to aid with turning and positioning while in bed due to left sided weakness related to cerebral vascular accident (CVA/ stroke). The order had been discontinued on 8/31/24.

Resident #1's medication administration record for August 2024 revealed an order dated 6/11/24 that read: Eliquis Oral Tablet 5 milligrams (mg) (Apixaban) give 1 tablet by mouth two times a day for DVT for 90 Days. The MAR indicated that her Eliquis had been held on 8/30/24 and 8/31/24.

A progress note dated 8/30/24 by Nurse #1 read: "Resident (Resident #1) has a skin tear and skin bruising to left arm due to laying on bed rail. On call NP order an ultrasound to left arm to rule out DVT. Resident has no complaints of pain. Her left arm is propped on a pillow. Resident

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representative (RP) has been notified and aware of bruising. Resident has call bell within reach. She is awake watching tv, chest is falling and rising. Nurse will follow resident care plan."

An interview was conducted on 9/17/24 at 1:16 PM with Nurse #1. She was the assigned nurse for Resident #1 for the 11pm-7am shift on 8/29/24. She explained that she rounded every two hours during her shift and that she checked on Resident #1 during her rounds. She said that when she had checked on Resident #1 during her rounds Resident #1 had been asleep and her arms had been covered up with a blanket. She said Resident #1 did not like to sleep flat and her bed was elevated 30 to 45 degrees. Nurse #1 said at 5:15 AM when she had been doing her last round before starting her morning medication, Resident #1 had her arm raised up from the bed. She said she noticed Resident #1 had a bruise on her left arm and her left arm was puffy and swollen. Nurse #1 said the swelling and bruising/ discoloration started at the middle of her upper arm above the elbow and extended to a few inches below the elbow. She said the discoloration was purplish red in color and it went around the entire circumference of her arm at/ below the elbow. Nurse #1 said Resident #1 was able to move her arm and did not complain of any pain. She said Resident #1 did not have any open areas present to her left arm. Nurse #1 explained she called the on-call NP to notify them of the injury. She said she did not tell the NP Resident #1 was on Eliquis because she had not realized at the time Resident #1 took an anticoagulant medication. She said the on-call NP had ordered an ultrasound of the left arm to make sure she did not have a DVT in her left arm. Nurse #1 said she also called and notified the RP, the Director of

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Nursing, and Unit Manager (UM) #1. She said Resident #1 had been positioned on her back in the bed and she did not see her arm in or against the bed rail assist bar during her shift. She said when she had found the area on Resident #1's left arm there had been nothing else around or in the bed with Resident #1 that could have caused the injury to Resident #1's left arm except the bed rail assist bar had been located on the left side of Resident #1's bed. Nurse #1 explained that because of how the injury to Resident #1's arm had looked and the location of the injury on her arm correlated to where the bed rail assist bar was located on Resident #1's bed. She said Resident #1 was unable to reposition herself in the bed and she required total staff assistance with bed mobility. Nurse #1 said Resident #1 could not use the bed rail assist bar to turn/ reposition herself in the bed. She explained Resident #1 would sometimes put her hand onto the rail and hold the rail with her hand, but she could not use the rail to assist with moving herself in bed.

An interview was conducted with Nurse Aide (NA) #1 on 9/17/24 at 1:34 PM. NA #1 said she had worked the 11-7 shift on the night of 8/29/24. She said she had done rounds every 2 hours that night for Resident #1 and had provided incontinent care. She said she had rolled Resident #1 onto her left side when she had performed incontinent care. NA #1 said Resident #1 required total assistance with bed mobility and was not able to turn herself in bed. She stated she had performed rounds around 2:00 AM and again between 4:00 AM- 4:40 AM. She stated she had been in Resident #1's room and had provided incontinent care right before Nurse #1 had found the area on her left arm and had not noticed

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anything unusual. She stated she had been present when the area to Resident #1's left arm had been found during Nurse #1's rounds. She stated Resident #1 had bruising that started right above her elbow and went a few inches down her arm past the elbow. She stated the bruising went around the circumference of Resident #1's arm at her elbow. She said she had not seen any marks or bruises on Resident #1's left arm when she had provided care that shift until Nurse #1 had found bruising to Resident #1's left arm around 5:00 AM. She stated she had not seen anything in or around Resident #1's bed that could have caused the injury to her left arm except the assist rail on the left side of the bed.

A progress note dated 8/30/24 by the on-call NP read: "Nurse reported resident's (Resident #1) left arm got stuck in the arm rail while sleeping. Bruising and swelling noted to arm. Not currently on blood thinners. Moving both arms equally. Order given for left upper arm ultrasound to rule out DVT per request of staff."

The on-call NP was not available for interview.

A progress note dated 8/30/24 by UM #1 read: "Nurse on the hall alerted me that the resident (Resident #1) had bleeding on left (L) forearm. Bleeding noted on L forearm, with blood noted in the bed, on the floor. Wound Care NP notified to assess the wound. Wound noted to be over 2 in. long with adipose tissue showing. Bleed uncontrolled initially with pressure. Wound Care NP recommended orders to send resident to the ED (emergency department) for further evaluation and treatment. Wound cleaned and continuous pressure applied. EMS (emergency medical system) called. Patient care report and

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all documentation provided to EMS crew. Resident transferred from bed to stretcher via draw sheet method."

An interview was conducted on 9/17/24 with UM #1 at 4:09 PM. UM #1 stated on 8/30/24 she had received a message on her phone around 5:00 AM from Nurse #1 asking for her to call Nurse #1 at the facility. UM #1 said Nurse #1 reported to her that Resident #1 had swelling and discoloration from the elbow to mid forearm of her left arm. She said Nurse #1 had not told her how the injury to her left arm had happened. UM #1 stated she contacted NP #1 about the swelling and discoloration of Resident #1's left arm. She explained NP #1 was the routine NP that came to the facility. UM #1 said NP #1 gave her an order to obtain an X-ray of Resident #1's left arm. UM #1 said she arrived at the facility a little before 7:00 AM for her shift on 8/30/24. She stated when she arrived at the facility, she went to Resident #1's room to check on her and assess her left arm. UM #1 said when she assessed Resident #1's left arm around 7:00 AM she had blue/ purplish discoloration to her left arm and swelling started above her left elbow and extended to her wrist. She said Resident #1 was able to move her left arm without difficulty, had a good pulse, and did not complain of any pain to her left arm. She said Resident #1 had not had any open areas to her left arm at that time. UM #1 said between 8:00-9:00 AM the floor nurse had come and gotten her out of the morning meeting stating Resident #1 had bleeding from her left arm. UM #1 said when she entered Resident #1's room she was sitting up in bed feeding herself breakfast using her left hand/ arm, and she had active bleeding from her left arm. She said there was a good amount of bleeding coming from an

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open wound on Resident #1's left forearm and there was blood on the bed and on the floor. UM #1 said when she saw the blood she went and got the Wound Care NP #1 who was in the building to come and assess the wound. UM #1 said the Wound Care NP #1 recommended to send Resident #1 out to the ED. UM #1 said EMS was called, and the family was updated. She said by the time EMS had arrived the swelling and discoloration to Resident #1's left arm had increased and extended into her hand and fingers.

A progress note dated 8/30/24 by Wound Care NP #2 read in part: "Nurse requested that patient (pt) be seen for left lower arm redness and swelling". Under the note section title new recommendations, the note read in part: "Pts left lower arm noted to have erythema, swelling, and tenderness. No opening noted. No drainage. Advised nurse to call primary team to determine if patient needs to be evaluated at a higher level of care. Per on-call physician, stat ultrasound ordered. Will defer care to primary team once results are available. No acute findings at this time. The risk of complications and/or morbidity/mortality of the patient's management is low. The patient was noted to have intact skin upon assessment today. The patient has moderate/high risk for skin breakdown."

An interview was conducted on 9/18/24 with Wound Care NP #2 at 2:39 PM. The Wound Care NP #2 stated she had arrived at the facility around 5:15 AM on 8/30/24. She said Nurse #1 had asked her to look at Resident #1's arm and she had seen Resident #1 around 5:30 AM. The Wound Care NP #2 stated Resident #1 had erythema and swelling to her left arm, but her

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skin had been intact with no open wounds. She said the discoloration and swelling was from mid forearm to right above the elbow on Resident #1's left arm. She stated the area looked like a hematoma because it was red and swollen. She said the area almost looked blood filled and like the blood had seeped into the skin a little bit. She said the area was very tight. The Wound Care NP #2 stated Resident #1 had not been able to say what had happened to her left arm. She explained that she had recommended that Nurse #1 call Resident #1's primary care provider to see if she needed to be seen at a higher level of care.

A progress note dated 8/30/24 by Wound Care NP #1 read in part: "Nurse requested that patient be seen for left lower arm swelling and actively bleeding wound. Under wound assessment it read: Size: 2.5 cm x 6 cm x 0.8 cm. Exposed Tissues: Dermis, Subcutaneous, Adipose. Peri wound: Edema, Intact, Significant ecchymosis noted. Exudate: Heavy amount of Sanguineous. Under the section titled new recommendations the note read: Patients (Pt) left lower arm noted to have erythema, swelling, and tenderness. Pt with active bleeding found by nurse, was asked by staff to evaluate. Bleeding being controlled with pressure but continues once pressure removed. EMS activated, pt condition stable. The risk of complications and/or morbidity/mortality of the patient's management is high."

An interview was conducted with Wound Care NP #1 on 9/18/24 at 2:40 PM. Wound Care NP #1 stated he saw Resident #1 on 8/30/24 between 8:30 AM and 9:00 AM. He said the nurse had run over to where he was in the building and said Resident #1 was actively bleeding and they needed something to stop the bleeding. He said

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4x4 gauze was used to apply pressure to the wound to control the bleeding. Wound Care NP #1 said that he told staff they needed to call EMS. The Wound Care NP #1 said Resident #1's wound "was busted open pretty good and pouring blood". He said the hematoma "was huge and there was a ton of swelling". The Wound Care NP #1 said if Resident #1 had reached or twisted her left arm that the strain on her fragile skin could have caused the hematoma to rupture because there had been so much swelling from the underlying hematoma. The Wound Care NP #1 said the staff had not said how the hematoma had happened. The Wound Care NP #1 said when he saw Resident #1 it had been an emergent medical focus of stopping the bleeding and calling EMS. He said anytime pressure was removed from the wound it started to pour blood again. He said depending on comorbidities and if someone was on a blood thinner that it was possible for a hematoma to happen that fast. He said with how fast the hematoma had ruptured it had probably occurred fast. The Wound Care NP #1 said with Resident #1 being on the blood thinner and with how thin and fragile her skin was, the hematoma had looked like a water balloon and looked like it would bust if you just poked it. The Wound Care NP #1 said Resident #1 using her left arm for breakfast, or the slightest bump could have caused the hematoma to rupture.

A progress note dated 8/30/24 by the Director of Nursing (DON) read: "During morning rounds nurse noted resident (Resident #1) to have bruise, skin tear, and swelling to left upper extremity. Resident assessed and on call notified. No pain or psychosocial ill effect noted. Order received for ultrasound and X ray. Wound care NP was in facility and evaluated area. RP notified

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and stated that she noted a small bruise to left forearm the previous day after using the bed pan where she was leaning on the halo during toileting. Daughter was present during toileting. While awaiting X-ray and ultrasound to be performed this morning the resident was eating breakfast. During breakfast while resident was feeding herself, she was noted to be bleeding from the left forearm. Resident is on Eliquis, Plavix, and aspirin. Wound care NP evaluated resident, and first aid applied. Order received to transfer to ER for further evaluation. RP made aware."

Review of Resident #1's August 2024 MAR indicated Plavix, and Aspirin were not ordered medications for Resident #1 and had not been received.

The hospital emergency department (ED) provider notes dated 8/30/24 read in part: "patient with past medical history of vascular parkinsonism (Parkinson symptoms (slow movements, tremor, difficulty walking, stiffness/ rigidity) that are caused by problems with the vessels in the brain), vascular dementia (changes in memory and thinking resulting from conditions that affect the blood vessels in the brain), left sided bell's palsy (a neurological disorder that causes weakness or paralysis of the muscles on one side of the face) presenting to the emergency department from nursing home for evaluation of left upper extremity wound and bleeding. Per nursing home report, patient slept with her left arm against a rail. When she woke up this morning there was significant bruising noted to the left arm as well as a wound near the left elbow with persistent bleeding. Given this patient was sent to the emergency department for

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evaluation. No reported falls. Patient is on Eliquis (anticoagulant medication). Emergency Medical Services (EMS) reports patient laid against something all night and it caused swelling and trauma to her left arm. They reported that the intense swelling caused the skin to open, and they reported the patient lost about 75 milliliters (ml) of blood and adipose tissue is visible. Under the physical exam section labeled skin the note read: Significant erythema (redness) of the left upper extremity from the left elbow to the left hand with associated swelling. Hand is warm to touch. Range of motion of the left elbow, wrist, hand, and fingers normal. No significant tenderness to palpation. Wound noted to the lateral aspect of the left proximal forearm with underlying hematoma. Under the section entitled medical decisions making and plan of care the note read in part: Suspect that the patient developed a hematoma which then caused a skin tear secondary to underlying pressure. It appears that she has an underlying hematoma in the region of the left elbow. Bleeding is controlled. Hemoglobin stable. Patients wound was irrigated and hematoma was evacuated. Given friable skin, unable to close with sutures due to concern of causing more damage. Steri-strips were placed over the area to loosely approximate. Wound was dressed with gauze and ABD pads (surgical pad) as well as a compression dressing using an ace wrap. Recommended that the patient hold her Eliquis for the next 2 days. Under diagnostic and labs section of the note: Hemoglobin (protein that carries oxygen in red blood cells) 12.2. The clinical impressions section of the note stated: Traumatic hematoma and ecchymosis of the left upper arm, skin tear of the elbow."

An interview was conducted with the Maintenance

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Director on 9/18/24 at 4:42 PM. He said that maintenance had removed the assist bar from Resident #1's bed on 8/30/24. He said he did not really know why the assist bar had needed to be removed.

On 9/19/24 at 2:27 PM an observation was completed of the bed rail assist bar device with the Maintenance Director. The bed rail assist bar was observed to be in the shape of a circle with a metal arm that connected the circular assist bar to the bed frame. The circular part of the assist bar had 7 openings within the circle that were different sizes and shapes. The largest opening within the circle was triangular and measured 6 inches in width and 4 inches in height. The surveyor was able to insert an arm up to mid forearm into 3 of the 7 openings and was able to insert an arm past the elbow into 2 of 7 openings. The circular bed rail assist bar was also observed in place on a resident bed with the Maintenance Director. Using a tape measure the Maintenance Director measured the gaps between the mattress and the bottom of the assist bar. With the bed in the flattest position there was a gap between the bottom of the rail and the mattress of approximately 1 inch. With the bed positioned in an upright position at a 75 degree angle the bed rail assist bars were observed to be parallel with the mattress and there was a gap between the bottom of the assist rail and the mattress that measured 5.5 inches.

An interview was conducted with the DON on 9/18/24 at 11:02 AM. The DON stated through the facility investigation it was determined that the injury to Resident #1's left arm was from the bed rail assist bar located on the left side of Resident #1's bed. She said staff and family had reported

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that Resident #1's left arm was seen pushed up against the bed rail assist bar when staff would turn/ roll her onto her left side for toileting care. She said the injury to Resident #1's left arm had correlated with the location and position of the bed rail assist bar on the left side of the bed. She said during the facility's investigation it was found there was nothing else around or in the bed that could have caused the injury to Resident #1's left arm. She said Resident #1 had returned to the facility in the evening on 8/30/24 and the facility had done a new bed rail assessment on Resident #1. The DON said Resident #1 had not been able to use the bed rail assist bar without staff prompting. She said the bed rail assist bar had been removed from Resident #1's bed on 8/30/24. She said Resident #1 taking Eliquis did not necessarily mean she needed safety precautions, or it was a medication that required safety precautions. The DON said it was individualized for each resident if an anticoagulant medication increased the risk of bleeding and needed safety precautions. The DON stated Resident #1 had been sent back to the hospital on the morning of 8/31/24 because she had bleeding that had come through the dressing on her left arm that could not be controlled. She explained Resident #1 had been admitted to the hospital and did not return to the facility.

The ED to hospital admission provider notes dated 8/31/24 read in part under section titled medical decision making: "Acute blood loss anemia. Bleeding from wound. Patient with wound to left forearm at split heavily bleeding. Hemoglobin dropped from 12-8 roughly. Seen by general surgery recommending conservative measures and admission to the hospital for observation/ trend of hemoglobin and hematocrit

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(H&H). Surgery did have discussion with family regarding intervention in the operating room (OR). No evidence of compartment syndrome. Clinical impression and disposition: 1. Acute blood loss anemia 2. Bleeding from wound." Computed tomography (CT) of left upper extremity read in part: "There is a large subcutaneous hematoma over the dorsal aspect off the left forearm, which is incompletely included on the exam, measures approximately 8 x 3.5 cm transverse dimensions and extends over the length of the left forearm from the elbow to the dorsum of the hand. There is a small 6 mm blush (a predictor of hematoma progression) along the central aspect of the hematoma which is felt to represent small venous oozing. This is not arterial bleeding or arterial in source. No fractures seen." Her initial hemoglobin on 8/31/24 at the ED was 8.5. Further review of the hospital records revealed that Resident #1's subsequent hemoglobin levels on 8/31/24 were 7.7 and 6.7 and that she required transfusion with 2 units of packed red blood cells (PRBCs) during her hospitalization.

An interview was conducted with Resident #1's family member. The family member stated she had visited Resident #1 on 8/29/24. She said because Resident #1 took a blood thinner she always "looked her over really well" for any bruising and she had not seen any marks or bruising on her left arm when she had visited on 8/29/24. She said she would have noticed and remembered if Resident #1 had had any new areas or marks.

An interview was conducted with NP #1 on 9/19/24 at 10:46 AM. The NP #1 stated Resident #1's left arm being pressed up against the bed

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rail assist bar could have caused the hematoma. She stated the rail was consistent with the location of where the hematoma was located on Resident #1's left arm. She said with the elderly it did not take a lot to create a hematoma because of fragile skin and Eliquis also increased the risk. She said Resident #1's hematoma was much more likely to be the result of being pressed up against something or hitting something than to be spontaneous. She said the swelling and discoloration was from the blood and gravity. She explained the blood would flow downward distally because of gravity. NP #1 stated the movement of Resident #1 using her arm to feed herself and the bending at the elbow would create more pressure and tension on the skin and could have caused the hematoma to spontaneously rupture. The NP #1 stated if a bump had happened at the elbow or side at the of the arm it could have caused the bruising to go around the circumference of the arm with gravity. She said if Resident #1 had bumped her arm early than the morning of 8/30/24 then the bruising would have shown up quickly, within 10 minutes and would have already been visible before the injury had been found by Nurse #1.

An interview was conducted with the Administrator on 9/10/24 at 11:46 AM. The Administrator stated during the facility's investigation of the injury to Resident #1's left arm staff said they had seen Resident #1 roll against the bed rail assist bar and press against the rail located on the left side of the bed. He stated Resident #1 was on a blood thinner. He said with leaning against the rail and with her being on the blood thinner that it was thought to have caused the injury. The Administrator stated through the facility investigation there had been nothing else

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found that correlated and could have caused the injury. He stated they had looked at Resident #1's room and bed and that the injury on Resident #1's left arm had correlated with the location of the bed rail assist bar located on the left side of her bed.

An interview was conducted with the Medical Director on 9/19/24 at 2:00 PM. He said he had not seen Resident #1 since her injury. He said he had not been aware of Resident #1's left arm injury or hospital transfers until today. He stated that was not uncommon because the staff would contact the NP at the facility and the on-call staff to address issues at the facility. He stated the elderly have fragile skin and Eliquis increased the risk of bleeding for anyone who took the medication. He said a hematoma could happen spontaneously or very easily from any small bump if someone took an anticoagulant.

The facility provided the following Corrective Action Plan with a correction date of 8/31/24:

HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

On 8/30/2024 Resident # 1 sustained an injury from her Assist Side Rail. At approximately 5:20 a.m. Resident # 1 was noted to have a bruise, with hematoma and abrasion and some swelling to her left upper extremity that measured 2.5 cm (centimeters) X 6.0 cm. X 0 cm, by the charge nurse. First Aid applied and the on-call provider was notified. Received order to obtain a doppler ultrasound to rule out DVT due to history of DVT's.

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On 8/30/24 Resident #1's Responsible Party was notified of injury by the charge nurse at 5:40 a.m.

At approximately 8:55 a.m. while the resident was eating breakfast independently the hematoma to her arm burst, charge nurse and unit manager applied pressure and notified wound care provider who was in house and came to bedside to assess the resident. Orders were received to send the resident to the emergency room (ER) for evaluation, resident sent to ER at approximately 9:10 a.m. Resident returned from the hospital at approximately 6:00 p.m. on 8/30/24 with pressure dressing to left forearm and no new orders. Eliquis was held on 8/30/24.

On 8/30/2024 Resident #1 was reassessed for use of bed rails. The Assessment revealed that the resident was not able to utilize the Assist Side Rails without staff prompting, and this put her at further risk for injury as well as her having vision impairment, dementia, diagnosis of muscle weakness and being on a blood thinning medication.

On 8/30/2024 Assist Side Rail was removed from Resident #1's bed.

Resident was sent back out to the ER on 8/31/24 at approximately 8:30 a.m. when the charge nurse noted that resident was bleeding through the pressure dressing and the bleeding could not be controlled. Resident was admitted to the hospital on 8/31/24 and resident has not returned to the center.

ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL

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F 689	Continued From page 19 TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: On 8/30/24 the Director of Nursing, Administrator and clinical team completed a root cause analysis for this event and determined Resident #1 had an assist side rail which contributed to an injury. The facility failed to recognize that the vision impairment, dementia, diagnosis of muscle weakness and being on a blood thinning medication placed resident at risk for an accident. On 8/30/2024 Nursing leadership (which included the Director of Nursing and Unit Managers) in conjunction with the Wound Care Nurse Practitioner completed 100% audit of all current residents with Assist Side Rails in use, for skin integrity to ensure no other injuries related to assist rails. No injuries noted. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: On 8/30/2024 Nursing Staff, including nurses and Certified Nursing Assistants (CNAs), including agency staff were educated by the Director of Nursing and Staff Development Coordinator (SDC) regarding bed mobility and ensuring resident's safety with bed rails. Education also included an assessment of bed rails for residents to ensure residents safety with use, to include review of vision status, bed mobility, cognitive status and medications which put resident at risk. Nurses Aides were educated on bed mobility and observing for changes and any concerns related to residents' use of side rails, ie: leaning on them, limbs against them/through them, resting head	F 689		

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against rails, not being able to grasp independently). If they note any concerns with safety to report to the charge nurse immediately. This education is ongoing with no staff working until education is completed. Director of Nursing and/or Designee will ensure new hires or agency staff receive the education. The Director of Nursing is responsible for tracking and educating staff who were not educated on 8/30/24. This education was completed in person.

HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ASSURE THE SOLUTIONS ARE SUSTAINED:

On 8/30/24 the Administrator and Director of Nursing made the decision to implement a weekly audit. Audits of residents with Assist Side Rails X 4 weeks, then quarterly thereafter, to ensure that the resident remains appropriate for use of Assist Side Rails and that there are no signs of injury from Assist Side Rail use. The Director of Nursing is responsible for these audits. The Administrator and Director of Nursing made the decision via an AD HOC Quality Assurance Performance Improvement (QAPI) meeting on 8/30/24 and decided results of ongoing audits will be taken to the monthly QAPI meeting. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting with the QAPI Committee responsible for ongoing compliance.

Date of Compliance: 8/31/24

On 9/19/24, the facility's corrective action plan effective 8/31/24 was validated by the following: The facility incident logs were reviewed from August 2024 through September 2024 and

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F 689	Continued From page 21 revealed no additional residents had sustained an injury related to the use of assist side rails. All residents with assist side rails currently in use were reviewed. The facility had reassessed all residents on 8/30/24 for risk factors that could affect their ability to safely use assist side rails. The facility had removed assist side rails from the resident beds that were assessed as not able to safely and independently use them. The facility audit for assist side rails was reviewed and revealed that the facility was conducting audits weekly of residents with assist side rails in use for safety and to ensure they remained safe to use the assist side rails. Interviews were conducted with nurses and nurse aides (NA's). The nurses and NAs had received education from the facility on bed mobility and ensuring resident safety with using bed rails. The NA's had been educated to report changes in a resident's ability to use bed rails or concerns with safety. Interviews with nurses revealed they had been educated on the bed rail assessment to assess for risk factors that could affect a resident's safety using assist side rails. The education included new staff and contract/agency staff. New staff and contract/ agency staff were not allowed to work until education had been received. The facility's action plan was validated to be completed as of 8/31/24.	F 689		
F 700 SS=G	Bedrails 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	F 700		

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F 700	Continued From page 22 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, Nurse Practitioner (NP), family, and staff interviews, the facility failed to accurately assess a resident (Resident #1) for bed rail assist bars, failed to assess a resident (Resident #1) prior to implementation of bed rail assist bars, and failed to review the risks associated with the use of bed rail assist bars with Resident #1's Resident Representative. Resident #1 sustained a hematoma to her left arm from the bed rail assist bar and was transferred to the hospital emergency room on 8/30/24 and 8/31/24 for treatment. Resident #1 was admitted to the hospital related to her hematoma injury on 8/31/24 and required a blood transfusion during her hospitalization. This deficient practice occurred for 1 of 5 residents reviewed for bed rails. Findings included:	F 700	Past noncompliance: no plan of correction required.	

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Resident #1 was admitted to the facility on 7/9/24 with the following diagnoses: vascular parkinsonism (Parkinson symptoms, slow movements, tremor, difficulty walking, stiffness/ rigidity that are caused by problems with the vessels in the brain), dementia, left sided bell's palsy (a neurological disorder that causes weakness or paralysis of the muscles on one side of the face), macular degeneration (eye disease that causes blurred or reduced central vision), spondylosis with radiculopathy, cervical (neck) region (nerve condition that causes pain, weakness, and numbness that can spread into the shoulder, back, and arm), right shoulder osteoarthritis, history of deep vein thrombosis (DVT/ blood clot).

There was not a bed rail assessment.

Resident #1's medication administration record (MAR) revealed an order dated 6/11/24 that read: Eliquis oral tablet 5 milligrams (mg) (Apixaban) give 1 tablet by mouth two times a day for DVT for 90 Days.

Review of the admission minimum data set (MDS) assessment dated 7/15/24 revealed that Resident #1 had severe cognitive impairment. She was not documented for behaviors or rejection of care. Resident #1 was coded as having impaired vision and upper extremity impairment on one side. She was also documented on the MDS that she required substantial/ maximum assistance with rolling in bed and transfers. Resident #1 was not coded for a restraint or bed rails.

Review of Resident #1's physician orders

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revealed an order dated 7/19/24 that read: [brand name assist bar] to left side of bed to aid with turning and positioning while in bed due to left sided weakness related to cerebral vascular accident (CVA/ stroke).

Review of the electronic medical record revealed that Resident #1 had a bed rail/ assist device assessment that had been completed on 7/19/24 by the Director of Nursing. The assessment indicated that Resident #1 did not have fluctuations in levels of consciousness or cognitive deficit, did not have visual deficits, and did not take medications that required safety precautions. The assessment was not filled out accurately.

Resident #1's medical record revealed an incomplete consent form titled consent for use of side rail (s) or grab bars/ canes. Resident #1's name was at the top of the form along with the date 7/19/24. The indication for use of side rails/ grab bars was unmarked. The risk section of the form had three check boxes that reviewed the potential risks associated with the use of bed rail/ assist bars that included: getting caught in the rails, grab bars/ and or between rails/ bars and mattress (entrapment) or death, skin tears or bruises caused by hitting against the rails/ bars, fall from over top of the side rail places resident at increased risk for greater injury even death. The check boxes reviewing the risks were unmarked. The bottom of the consent form had been signed by Family Member #2 and was dated 7/22/24. The form had been signed by Unit Manager #2.

UM #2 no longer worked at the facility and was not available to be interviewed.

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An interview was conducted on 9/19/24 at 12:06 PM with the DON. The DON said a bed rail assessment was supposed to be done when bed rail assist bars were implemented and then quarterly. She could not say why a bed rail assessment or a consent for bed rails had not been completed when Resident #1 was admitted to the facility on 7/9/24 or prior to the bed rail assist bar being implemented for Resident #1, except that it had been missed. The DON said she had completed a bed rail assessment for all residents that had bed rail assist bars in use, including Resident #1 on 7/19/24 because corporate had called and directed her to do so. She did not know why corporate had requested bed rail assessments to be done. She explained when she did the bed rail assessment for Resident #1, she had not observed Resident #1 use the bed rail assist bar. She stated she had completed the assessment based off what staff had told her and documentation. The DON stated she had attended the care plan meetings with Resident #1's family. The DON did not remember the risks associated with using bed rail/ assist bars being reviewed with the family during the care plan meetings. The bed rail consent form for Resident #1 was reviewed with the DON. She declined to comment if the check boxes on the form under the risk section should be marked to indicate that the risks next to each check box had been reviewed. The DON said if she had completed the consent form, she would have checked the boxes, but everyone had a different way of doing things. She said she would expect staff to fill out the consent form correctly. The DON said she was not sure if UM #2 had understood the consent form correctly. She stated she would have expected UM #2 to have

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asked if she had not understood how to complete the consent form. The DON said when Resident #1 had moved to the skilled nursing facility bed she was a new admission, and everything needed to be redone/ reassessed. She said if a resident requested or needed a bed rail assist bar the bed rail assessment and bed rail consent form should be completed before the assist bar was implemented.

An interview was conducted with NP #1 on 9/19/24 at 10:46 AM. NP #1 stated she had participated in the care plan meeting on 7/9/24 with the family and said the bed rail assist bar had not been discussed. NP #1 reviewed the bed rail/ assist bar consent form; she said the boxes should be marked under the risk section to indicate that those areas were reviewed with the family/ resident. She said if the boxes were not marked it could not be said if the areas had been reviewed. She said that the bed rail/ assist bar consent form and the bed rail assessment should be done before bed rail assist bars were initiated.

An interview was conducted with Family Member #1 on 9/17/24 at 12:17 PM. Family Member #1 stated the facility had not talked to her about the risks associated with Resident #1 using the assist bar. Family Member #1 had been present and helped move Resident #1's belongings to her new room in the skilled facility on 7/9/24. She said that the new bed in Resident #1's room had not had the assist bar on it originally but that the facility had put it on the bed within a day or two.

An interview was conducted on 9/19/24 at 9:15 AM with Family Member #2. She said when Resident #1 moved to her new room in the skilled facility the assist bar had been placed on the new

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bed the same day 7/9/24 or maybe the next day 7/10/24. Family Member #2 had signed the bed rail consent form for Resident #1. She stated the nurse did not explain or discuss anything on the bed rail consent form. She said it had been presented to her as Resident #1 "needed to have new forms signed for her admission and for her to have the bed rail assist bar". She stated the risks of using the bed rail assist bars such as death, entrapment, or bruising had not been discussed or mentioned by anyone at the facility. She said UM #2 had presented all the paperwork to her "as the facility needed new paperwork filled out because she (Resident #1) had moved".

Review of a progress note dated 8/30/24 by Nurse #1 read in part: Resident (Resident #1) has a skin tear and skin bruising to left arm due to laying on bed rail. On call NP order an ultrasound to left arm to rule out DVT. Resident has no complaints of pain. Her left arm is propped on a pillow. Resident representative (RP) has been notified and aware of bruising.

An interview was conducted on 9/17/24 at 1:16 PM with Nurse #1. She was the assigned nurse for Resident #1 for the 11pm-7am shift on 8/29/24. Nurse #1 said that at 5:15 AM when she had been doing her last round Resident #1 had her arm raised up from the bed. She said she noticed Resident #1 had a bruise on her left arm and that her left arm was puffy and swollen. Nurse #1 said the swelling and bruising started at the middle of her upper arm above the elbow and extended to a few inches below the elbow. Nurse #1 explained the location of the injury on Resident #1's left arm had correlated with where the bed rail assist bar was located on the bed.

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A progress note date 8/30/24 by UM #1 read: "Nurse on the hall alerted me that the resident (Resident #1) had bleeding on left (L) forearm. Bleeding noted on L forearm, with blood noted in the bed, on the floor. Wound Care NP notified to assess the wound. Wound noted to be over 2 in. long with adipose tissue showing. Bleed uncontrolled initially with pressure. Wound Care NP recommended orders to send resident to the ED (emergency department) for further evaluation and treatment. Wound cleaned and continuous pressure applied. EMS (emergency medical system) called. Patient care report and all documentation provided to EMS crew. Resident transferred from bed to stretcher via draw sheet method."

Review of the hospital emergency department (ED) provider notes dated 8/30/24 read in part: "Patient presented to the emergency department from nursing home for evaluation of left upper extremity wound and bleeding. Per nursing home report, patient slept with her left arm against a rail. When she woke up this morning there was significant bruising noted to the left arm as well as a wound near the left elbow with persistent bleeding. Patient is on Eliquis (anticoagulant medication)."

A progress note dated 8/31/24 by on-call NP #2 read in part: "Nurse reports uncontrolled bleeding to hematoma on arm. Was recently sent to emergency room due to bleeding, returned with order for pressure dressing however nursing has attempted to reapply the pressure dressing and apply pressure to site but bleeding continues, dressing is saturated. Instructed to notify EMS due to uncontrolled bleeding."

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Review of the ED to hospital admission provider notes dated 8/31/24 read in part under section titled medical decision making: "Acute blood loss anemia (low hemoglobin), Bleeding from wound. Patient with wound to left forearm at split heavily bleeding. Hemoglobin (protein in red blood cells that carry oxygen) dropped from 12-8 roughly. Seen by general surgery recommending conservative measures and admission to the hospital for observation/ trend of hemoglobin and hematocrit (H&H). Computed tomography (CT) of left upper extremity read in part: There is a large subcutaneous hematoma over the dorsal aspect of the left forearm, which is incompletely included on the exam, measures approximately 8 x 3.5 centimeters (cm) transverse dimensions and extends over the length of the left forearm from the elbow to the dorsum of the hand. There is a small 6-millimeter (mm) blush (a predictor of hematoma progression) along the central aspect of the hematoma which is felt to represent small venous oozing. This is not arterial bleeding or arterial in source. No fractures seen."

Additional review of the hospital records revealed Resident #1's subsequent hemoglobin levels on 8/31/24 were 7.7 and 6.7 and that she required transfusion with 2 units of packed red blood cells (PRBCs) during her hospitalization.

On 9/19/24 at 2:27 PM an observation was completed of the bed rail assist bar device with the Maintenance Director. The bed rail assist bar was observed to be in the shape of a circle with a metal arm that connected the circular assist bar to the bed frame. The circular part of the assist bar had 7 openings within the circle that were different sizes and shapes. The largest opening within the circle was triangular and measured 6

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inches in width and 4 inches in height. The surveyor was able to insert an arm up to mid forearm into 3 of the 7 openings and was able to insert an arm past the elbow into 2 of 7 openings.

The facility provided the following Corrective Action Plan with a correction date of 8/31/24:

HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

On 8/30/2024 Resident #1 sustained an injury from her Assist Side Rail. At approximately 5:20 a.m. Resident #1 was noted to have a bruise, with hematoma and abrasion and some swelling to her left upper extremity by the charge nurse, measuring 2.5 cm (centimeters) X 6.0 cm X 0 cm. First Aid applied and the on-call provider was notified. Received order to obtain a doppler ultrasound to rule out DVT due to history of DVTs. At approximately 8:30 a.m. while Resident #1 was eating breakfast independently the hematoma to her arm burst, charge nurse and unit manager applied pressure and notified wound care provider who was in house and came to bedside to assess the resident. Orders were received to send the resident to the emergency room for evaluation.

Resident #1 moved from an Assisted Living bed to a SNF bed on 7/09/24 with Assist Side Rails on her bed as she had had them in the Assisted Living. Resident should have had an assessment completed on 7/9/24 due to new admission. Resident #1 was reassessed for Bed Rail safety/use by the Director of Nursing (DON) on 7/19/24. This assessment determined the

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resident utilized Assist Side Rails with staff assistance. This was not an accurate assessment based on not including Resident # 1's cognitive loss, vision concerns, muscle weakness and use of anticoagulant medications.

On 8/30/2024 Resident #1 was reassessed for use of bed rails. The Assessment revealed that the resident was not able to utilize the Assist Side Rails without staff prompting, and this put her at further risk for injury as well as her having vision impairment, dementia and being on a blood thinning medication.

On 8/30/2024 Assist Side Rail was removed from Resident #1's bed.

ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

On 8/30/24 the Director of Nursing, Administrator and clinical team completed a root cause analysis of this event and determined Resident #1 was not able to utilize the assist side rails without staff prompting due to cognitive status. Resident #1 had muscle weakness and was not able to reach her arm over independently. This root cause analysis noted inaccuracies in the completion of bedrail assessment and the Consent and Review of Risks to Resident #1's responsible party were not completed prior to implementation of Assist Side Rails.

On 8/30/24 The Regional Director of Clinical Services educated the DON regarding completing the assessment accurately and consents with review of risks with RP and/or Resident. This

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included that the Director of Nursing visualizes the Assist Side Rail with Head of Bed elevated, size of rails, to ensure no gaps or risk for entrapment. The DON was educated before she completed assessments on 8/30/24 regarding accurate assessments and consents.
On 8/30/2024 Director of Nursing completed a new Bed Rail Assessment on all current residents with Side Rail Assist Bars in place to ensure appropriately assessed, three additional residents had Side Rail Assist Bars removed according to new assessments. Director of Nursing visualizes the Assist Side Rail with Head of Bed elevated, size of rails, to ensure not gaps or risk for entrapment. Consents were obtained by DON and/or Clinical Designee for any resident who was assessed for appropriate use of Assist Side Rails.

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR:

On 8/30/2024 Nursing Staff, including nurses and Certified Nurse Aides (CNAs) were educated by the Staff Development Coordinator (SDC) and Director of Nursing (DON) how to accurately complete the Bed Rail Assessment, and completion of the consent for rail use and educating the Resident or Responsible Party (RP) on risk of use. On 8/30/24 Agency and contracted staff were educated by SDC and DON how to accurately complete Bed Rail Assessment, completion of the consent for rail use and educating the Resident or RP on risk of use.
The Director of Nursing is responsible for ensuring this education is completed. Education also included an assessment of bed rails for

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residents to ensure residents safety with use, to include review of vision status, bed mobility, cognitive status and medications which put resident at risk. The Director of Nursing is responsible for tracking and educating staff not educated on 8/30/24. This education is ongoing with no staff working until education is completed. Director of Nursing and/or Designee will ensure new hires or contracted staff receive the education. This education was completed in-person.

The Regional Director of Operations met with the Maintenance Director on 8/30/24 and reinforced education with him on ensuring that he follows manufacturers' recommendations for installation of assist side rails.
When a resident that has had Assist Side Rails on their bed discharges, the Maintenance Director removes the rails from the bed.
Admissions and discharges are discussed in the morning meeting and the Maintenance Director is informed of residents who have been discharged so that he can remove any rails on the bed. This has been an ongoing process and was reinforced by Regional Director of Clinical Services on 8/30/24 with the DON, Staff Development Coordinator, Maintenance Director, Administrator, Unit Managers and Therapy. If a new admission would benefit from or a new request for Assist Side Rails, then DON and Therapy will meet with Maintenance Director to assess if Assist Side Rail is appropriate.

HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ASSURE THE SOLUTIONS ARE SUSTAINED:

Beginning 8/30/24 The Director of Nursing/

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Designee will assess any newly installed Assist Side Rails for any gaps head of bed elevated, size of rails, to ensure no gaps or risk for entrapment. They will assess the location of bed rail so that it meets the individual mobility requirements as well as position of rail when the head of the bed is in an elevated position, this process began on 8/30/24.

Review of audits resulted in the decision to implement a weekly audit of all residents with Assist Side Rails X 4 weeks, then quarterly thereafter, to ensure that the resident remains appropriate for use of Assist Side Rails and that there are no signs of injury from Assist Side Rail use. The Director of Nursing is responsible for these audits. The quarterly audits will be ongoing until the QAPI Committee determines they can be discontinued. The Administrator and Director of Nursing made the decision via an AD HOC Quality Assurance Performance Improvement (QAPI) meeting on 8/30/24 and decided results of ongoing audits will be taken to the monthly QAPI meeting. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting with the QAPI Committee responsible for ongoing compliance.

Date of Compliance: 8/31/24

On 9/19/24, the facility's corrective action plan effective 8/31/24 was validated by the following: All residents with assist side rails currently in use were reviewed. The facility had reassessed all residents on 8/30/24 for risk factors that could affect their ability to safely use assist side rails. The facility had removed assist side rails from resident beds who were assessed as not able to

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safely and independently use them. The facility audit for assist side rails was reviewed and revealed the facility was conducting audits weekly of residents with assist side rails in use for safety and to ensure they remained safe to use the assist side rails. The assist side rail audit included assessing for gaps that could lead to entrapment, completion of the side rail consent form, and bed rail assessment. Interviews were conducted with nurses and nurse aides (NA's). The NA's had been educated to report changes in a resident's ability to use bed rails or concerns with safety. Interviews with nurses revealed they had been educated on how to accurately complete the bed rail assessment and assessing for risk factors that could affect a resident's ability to safely use assist side rails. Nurses had also been educated on completing the side rail consent form and reviewing the risks associated with using side rails with the resident representative/ resident. Nurses were able to verbalize the side rail assessment and consent form should be completed prior to the assist side rails being implemented. Nurses verbalized that assist side rails were installed by maintenance once they were approved by nursing management and therapy. The education included new staff and contract/agency staff. New staff and contract/ agency staff were not allowed to work until education had been received

The Maintenance Director was interviewed and verbalized assist side rails were installed according to the manufacture directions and removed from the bed by maintenance when a resident was discharged. He verbalized when assist side rails were installed the rails were inspected for gaps between the rail and the mattress.

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F 700	Continued From page 36 The facility's action plan was validated to be completed as of 08/31/24.	F 700		