

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

**ORIGINAL**

PRINTED: 01/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435130</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHANY HOME - BRANDON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3012 E ASPEN BLVD</b> <b>BRANDON, SD 57005</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/6/13 through 11/7/13. Areas surveyed included resident care issues, coordination of hospice services, and neglect. Bethany Home - Brandon was found not in compliance with the following requirements: F280, F281, F309, and F323.	F 000	This facility denies that the alleged facts as set forth constitute the deficiencies under interpretations of Federal and State Law. The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility that of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452	F 280	F 280 The facility residents do have the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  Comprehensive Care Plans are developed within 7 days after completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a Registered Nurse with Responsibility for the Resident, and other appropriate staff in disciplines as determined by the resident needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment	12/07/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Annexa J...*

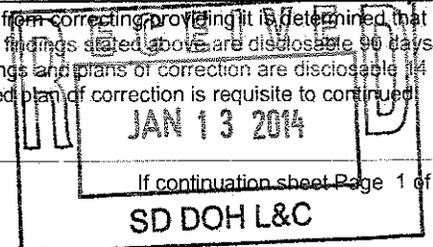
TITLE

*Administrator*

(X6) DATE

*12-5-13*

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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F 280	Continued From page 1 Based on record review and interview, the provider failed to ensure the use of grab bars for bed mobility were addressed on the plan of care for two of two sampled residents (1 and 2). Findings include:  1. Review of resident 1's undated care plan revealed: **"Impaired cognitive (memory) function." **"High risk for falls. Bed in low position at night. Encourage to use call light." **"Has pressure relieving mattress on his bed." **"Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface." **"Is extensive assist of 1 to 2 staff participation to reposition or turn in bed." *The use of the grab bars or his ability to use them with bed mobility were not addressed.  2. Review of resident 2's undated care plan revealed: **"Impaired cognitive function related to Alzheimer's disease." **"Is at high risk for falls." **"The bed in low position, floor mat next to bed, no handrails on bed, and personal items within reach.*"Totally dependent on staff for repositioning and turning in bed." *The use of the grab bars or his ability to use them with bed mobility from 10/29/12 until 1/1/13 were not addressed. (Was addressed on 1/1/13 incident report he had never been able to use them).  3. Interview on 11/7/13 at 11:45 a.m. with registered nurse (RN) N regarding the above revealed: *Resident 1 could sometimes use the grab bar	F 280	F280 Contd.  1. Resident # 1 is no longer a Resident of the facility.  Resident # 2's use of / need for grab bars for bed mobility was assessed and the Comprehensive Plan of Care updated by the Interdisciplinary Team on 1/02/13 The Resident and Responsible Party was informed of the care plan update on 1/02/13.  2. All Residents with Grab Bars for Bed Mobility are at risk.  3. The following policies were reviewed/ updated/implemented by the QAA Committee on 12/2/13: Assessment/Care Planning the use of Bed Rails Updated, Facility Bed Rail Policy - New Policy approved, Fall Prevention Policy - Reviewed/Updated  4. The following policies were reviewed/ updated/implemented by the QAA Committee on 12/2/13: Assessment/Care Planning the use of Bed Rails Updated, Facility Bed Rail Policy - New Policy approved, all Prevention Policy - Reviewed/Updated  The interdisciplinary Care Plan Team and All staff were educated on the Assessment/Care Planning the use of Bed Rails and the Facility Bed Rail Policy on 12/2-6/13 by the DNS		

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F 280	Continued From page 2 that was on the left side of his bed but not always. He never used his call light for assistance either. *Grab bars were on resident's beds, because the beds came that way. None of the residents had been assessed if they used them for bed mobility prior to 10/20/13. *The use of the grab bars should have been addressed on the resident's care plans so all staff would know to encourage them to use them consistently. *If the grab bars were addressed on resident's care plans staff would also be more aware which residents could not use them, and they could be removed from the bed.  4. Review of the provider's 8/10/12 care plan policy revealed "The plan of care identifies problems, approaches, goals, and the services necessary to assist the resident in attaining the highest practicable level of functioning."	F 280	F280 Contd.  All Residents with Grab Bars for Bed Mobility were assessed for appropriateness on 10/21-22/13 separately by nursing and therapy staff. Any grab bars deemed inappropriate were removed. After review by the QAA Committee, Grab Bars were deemed unsafe for residents on 11/29/13 and were removed by 12/3/13. Any future residents insisting on having Grab Bar(s) for bed mobility will be assessed by nursing and therapy, risk and benefits will be assessed, waivers will be obtained from the resident and the responsible party, along with orders from the physician. The resident's care plan will be updated by the Interdisciplinary Care Plan Team.	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, policy review, job descriptions, and daily staffing record review for 10/19/13 and 10/20/13 the provider failed to ensure professional standards were followed for: *Resident assessment; *Physician, hospice, and family notification of changes; *Documentation for one of one sampled resident	F 281	4. The DNS or designee with monitor Compliance with the Policies for Assessment/Care Planning for the use of Bed Rails, the Facility Bed Rail Policy and the Fall Prevention Policy weekly X 12 then monthly thereafter. Five resident charts will be monitored per week X 12 then monthly thereafter.  5. The results of these audits will be Reported to the Facility QAA Committee Monthly for review and recommendations for further action to be taken. DNS or Designee Responsible	12/07/13

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F 281	<p>Continued From page 3</p> <p>(1) with an acute change in a condition; *Reallocation of staff to one of four nursing units (Maple Valley) to provide for increased care needs for one of one sampled resident (1). Findings include:</p> <p>1. Review of resident 1's undated care plan revealed: **"Is receiving hospice (terminal care) services." **"His needs will be met, he will be kept comfortable, and free from pain." **"Coordinate with hospice services." **"Is a high risk for falls related to impaired cognition (memory) and impaired mobility."</p> <p>Review of an undated registered nurse (RN) or licensed practical nurse (LPN) job description revealed: **"Implement clinical policies and procedures to ensure safe, sanitary, and efficient practices supporting professional standards of nursing care. Assure that documentation, medication administration, resident nursing care, safety, and resident rights are in compliance with facility standards." **"Monitor health, safety, and well-being of the residents." **"Observe and document information pertaining to changes in residents' functional status and personal needs." **"Assist in keeping the environment safe for residents."</p> <p>Review of the provider's revised August 2011 Care of the Dying Resident policy revealed: *When a resident's condition becomes critical: -Notify the physician. -Notify the family and clergy if family desires. *After a resident's death:</p>	F 281	<p>F281</p> <p>Services provided by the facility do meet professional standards of quality, inclusive of assessment and documentation of residents with an acute change in condition and has sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determine by resident assessments and individual plans of care.</p> <p>1. Resident #1 is no longer a Resident of the facility</p> <p>2. All residents are potentially at risk</p> <p>3. The facility QAA Committee Reviewed the Policy and Procedure for:  <input checked="" type="checkbox"/> Assessment /Documentation of Resident Acute Changes in Condition  <input checked="" type="checkbox"/> RN / LPN Job Descriptions,  <input checked="" type="checkbox"/> Facility Policy for Notification of Significant Change in Condition  <input checked="" type="checkbox"/> Communication process for the staff to request assistance to meet resident care and safety needs.  <input checked="" type="checkbox"/> Staffing for the the facility on 12/2/13 and deemed all to be in compliance with assuring Professional Standards.</p>	

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F 281	<p>Continued From page 4</p> <p>-Notify the physician. -Obtain an order from the physician to release the body to the mortuary. *Points of emphasis: -Documentation of symptoms, vital signs (blood pressure, pulse and respirations), care given, and those who were notified is extremely important. -The physician was to have been notified as soon as possible.</p> <p>Review of undated hospice information in resident 1's medical record revealed: **"Before getting any new orders and with any changes in condition call hospice services." **"Use nursing judgement to ensure the patient is safe, comfortable, and treated with any current as needed (PRN) medications/treatments. Then call the hospice nurse for further directions in care."</p> <p>Review of undated hospice service standards provided by the administrator revealed: **"A call must be made for every call received reporting a change in the patient's condition." **"To assess customer satisfaction, the director of clinical services must call the family the day after an evening or weekend call anytime there are changes in the resident's condition." **"We strive to be present at every patient's death."</p> <p>Review of a 11/6/13 faxed hospice change in condition notice from the hospice administrative registered nurse revealed the provider must notify hospice immediately: **"Regarding a significant change in the resident's physical, mental, social, or emotional status." **"Any clinical complications that suggests a need to alter the plan of care." **"A condition unrelated to the terminal condition</p>	F 281	<p>F281 Contd.</p> <p>4. All staff, including licenses Nurses were inserviced on 12/2-6/13 by the DNS on the Policy and Procedure for:  <input checked="" type="checkbox"/> Assessment and Documentation of Resident Acute Changes in Condition  <input checked="" type="checkbox"/> Facility Policy for Notification of Significant Change in Condition  <input checked="" type="checkbox"/> Communication process for the staff to request assistance to meet resident care and safety needs Critical Thinking skills for triage and rapid assessment                      The Training for Critical Thinking Skills for Triage and Rapid Assessment for Licensed Nurses will be conducted again by the DNS Monthly X 3.</p> <p>5. Compliance with the Policies/Protocols outlined in #3 above will be monitored for 5 Residents weekly X12 by the facility DNS and monthly thereafter.</p> <p>6. The results of this monitoring will be reported to the facility QAA Committee Monthly for review and recommendations for further action to be taken. DNS or Designee responsible</p>		

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F 281	Continued From page 5 that might require transfer of the resident from the facility." **A resident's death."  Interview on 11/6/13 at 1:45 p.m. with the director of nursing regarding the above revealed: *There was usually a total of seven staff on duty during the 10:00 p.m. to 6:30 a.m. shift. There was two staff on Cottonwood Court, Plum Creek, and Willow Wood Way. There was always only one staff on Maple Valley (a registered nurse [RN] or a LPN). *They had made some staffing changes for the 10:00 p.m. to 6:30 a.m. shift on 10/19/13 through 10/20/13. Some of the evening (2:00 p.m. to 10:30 p.m.) staff stayed later, and one staff member came in early that worked the 6:00 a.m. to 2:30 p.m. shift. *Despite those staffing changes the total number of staff hours was equivalent to 6.5 staff and should have been adequate to meet the nursing needs of all the residents on all the units. *Staffing for the 10:00 p.m. shift on 10/19/13 through 6:30 a.m. shift on 10/20/13 documented on the daily census sheet revealed: -Cottonwood Court: -- RN O from 10:00 p.m. to 12:00 a.m. -- LPN G from 2:00 a.m. to 6:00 a.m. -- CNA B from 10:00 p.m. to 2:00 a.m. -- CNA D from 10:00 p.m. to 6:00 a.m. -Maple Valley: -- LPN A from 10:00 p.m. to 6:30 a.m. -Plum Creek: -- RN C from 10:00 p.m. to 6:30 a.m. -- CNA P from 10:00 p.m. to 2:00 a.m. --CNA B from 2:00 a.m. to 6:00 a.m. -Willow Wood Way: -- LPN H from 10:00 p.m. to 6:30 a.m. *She agreed there was adequate staff for the four	F 281			

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F 281	<p>Continued From page 6</p> <p>units that night, but impaired nursing judgement interfered with a staff member from another unit staying on Maple Valley with LPN A due to the significant change with resident 1 and another resident that was awake hollering all night.</p> <p>*The nurses for that shift would have been able to make the determination increased staff needs should have been focused on Maple Valley that night.</p> <p>Interview on 11/6/13 at 2:10 p.m. with LPN A regarding resident 1 revealed:</p> <p>*Asked the 10:00 p.m. staff (LPN E and certified nursing assistant (CNA) (F) on 10/19/13 at approximately 10:20 p.m. to put a resident back in bed who had just had a projectile (forceful) emesis (vomiting), had decreased alertness and responsiveness, and was grey in color.</p> <p>*Told them if they did not put him back in bed she would have no one to help her. The resident required two staff assistance with the use of a Hoyer (mechanical) lift for transfers.</p> <p>*Was the only one on duty that shift in the Maple unit.</p> <p>*Spent the majority of her time between 10:00 p.m. on 10/19/13 and 3:20 a.m. on 10/20/13 going between resident 1's room and another female resident in the room next door to him who was yelling all night.</p> <p>*CNA B did come over from another unit to assist her with rounds (repositioning and toileting) the residents.</p> <p>*She did not consider his projectile (forceful) emesis, change in responsiveness, and grey colored skin tone was a significant change in his condition.</p> <p>*She did not notify the family or hospice services on 10/19/13 at 10:00 p.m. through 10/20/13 at 3:20 a.m. when he expired (died).</p>	F 281		

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F 281	Continued From page 7 *She did not notify the physician about his significant change in condition or his death. *She had asked the previous shift to lay him down in bed again after he had been vomiting, because she would have no help to lay him down. She was aware of his high risk for aspiration and his hospitalization in March 2013 with pneumonitis due to inhalation of food or vomitus.	F 281		
F 309 SS=G	Refer to F309. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, policy review, and product user-service manuals the provider failed to ensure: *The physical, mental, and psychosocial needs were met during a resident change in condition ending in death for one of one resident (1). *Appropriate assessment and care for one of one sampled resident (1) at end of life. *Fall incidents and the use of grab bars on the bed were assessed and evaluated for safety for two of two sampled residents (1 and 2). Findings include:	F 309	F309  Each Resident does receive and the facility does provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.  <b>Please cross reference POC for F 280 and F 281</b>  1. Resident #1 and #2 no longer reside in the facility  2. All Residents are identified to be potentially at risk.  1. The Facility Policy and Procedures for: ⊗ Prohibition of Mistreatment, Neglect and Abuse of Residents and Misappropriation of Property	12/07/13

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F 309	<p>Continued From page 8</p> <p>1. Review of resident 1's medical record revealed: *An 11/11/12 admission date. *Diagnoses of dementia with behavior disturbances and chronic kidney disease. *He had a grab bar on the left side of his bed since admission on 11/11/12. *There was no assessment of his ability to use the grab bar. *Hospice services had been initiated on 5/29/13 due to terminal diagnosis of end stage renal disease. *Hospice had put an alternating pressure mattress on the bed. *He expired (died) at the facility on 10/20/13.</p> <p>Review of resident 1's 5/29/13 physician's order regarding hospice care revealed: **"Terminal diagnosis end stage renal (kidney) failure." **"Patient's prognosis is six months or less if the disease runs its normal course."</p> <p>Review of resident 1's 5/29/13 hospice plan of care revealed: *Caregivers were knowledgeable of care and need to report changes of LOC (level of consciousness). *Facility staff was knowledgeable and involved in hospice plan of care for the patient. *Patient would receive personal care and hygiene including other activities of daily living to their optimal level. *Hospice nurse to coordinate plan of care with facility staff.</p> <p>Review of resident 1's 10/7/13 nursing progress notes revealed: **Nurse heard noise from resident's room. Found</p>	F 309	<p>F309 Contd.</p> <ul style="list-style-type: none"> <li>☉Fall Prevention Policy</li> <li>☉Incident Investigation and Reporting</li> <li>☉Maintenance of Clinical Records inclusive of accurate documentation, resident assessment, plan of care and services provided were reviewed/updated by the facility QAA Committee on 12/2/13 and deemed to meet the intent of the requirement.</li> </ul> <p>Facility Staff , inclusive of the Interdisciplinary Care Plan Team Members and Nursing were educated on the Policies and Procedures for :</p> <ul style="list-style-type: none"> <li>☉Prohibition of Mistreatment, Neglect and Abuse of Residents and Misappropriation of Property</li> <li>☉Fall Prevention Policy</li> <li>☉Incident Investigation and Reporting</li> <li>☉Assessment and Accurate Documentation of Resident Status, on 12/2-6/13 by the DNS</li> </ul> <p>2. The DNS or designee will monitor 5 Residents for compliance with the above Facility Policy and Procedures weekly X 12, then monthly thereafter.</p> <p>3. The results of these audits will be reported to the Facility QAA Committee Monthly for Review and Recommendations for further action to be taken. DNS or Designee Responsible</p>		

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F 309	<p>Continued From page 9</p> <p>him lying on floor mat next to bed with legs and torso on the floor next to his bed wrapped in the blanket."                      **"Resident's head was still on the bed. Did not appear to hit his head."                      **"Resident was propped on right side with pillows behind him."                      **"Bed was in lowest position. Floor mat on floor."                      **"Call light on bed. Resident does not use."                      **"Skin tear to right elbow 1.0 centimeter (cm) by 1.8 cm u-shaped."                      *There was no documentation the use and safety of the grab bar had been evaluated.</p> <p>2. Review of resident 1's 10/20/13 at 3:20 a.m. nursing progress notes revealed:                      **"CNA B entered room just ahead of writer (LPN A). CNA B turned and said [He is on the floor]. When writer got further in the room, resident was lying on his left side next to the bed."                      **"The bed was in lowest position with his neck caught on the side rail of the bed. Writer called for assistance from other staff. Registered nurse (RN) C and CNA D responded. We disengaged (took apart) the side rail and laid resident's head on a pillow."                      **"No respirations (breathing) noted and no pulse palpable (felt). Color of skin very pale and cool to touch. Resident was incontinent of urine and bowel movement. Assist of four staff resident was gently rolled over on to a sheet then lifted into bed. Resident was changed and cleaned up."                      **"Director of nursing (DON) was called, police called, and hospice nurse called. Paramedics responded with police. Necessary paperwork provided to both. Hospice nurse responded. DON responded and administrator. Police questions answered and paperwork provided. Police investigation completed and autopsy requested</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>by police. Resident's body was transferred per ambulance to a skilled hospital. DON notified family."</p> <p>Review of resident 1's 10/20/13 at 3:21 a.m. and 6:05 a.m. nursing progress notes by LPN A revealed:</p> <p>*3:21 a.m. "Resident was found on floor by bed with head caught between grab rail and mattress. Skin pale and cool to touch. No respiration or palpable pulse. Necessary phone calls and paperwork filled out with DON. Resident sent to skilled hospital per ambulance."</p> <p>*6:05 a.m. "CNA B entered room at 3:20 a.m. just ahead of writer. She stated he is on the floor. When writer went closer resident was lying on his left side on the floor by the bed, which was in position, with his head caught on grab bar on side of bed. Resident was pale and cool to touch. No pulse palpable or respiration noted. Resident was incontinent of urine and feces (bowel movement). Writer called for assistance from other staff. Side rail was disengaged and resident's head laid on a pillow. With assist of four persons resident was gently rolled onto a sheet, then lifted on to the bed with the sheet. Resident cleaned up and changed. DON was called. Hospice nurse called. Police called. Paramedics, police, DON, hospice nurse, and the administrator responded. Police assessed the situation and requested an autopsy. Body transported per ambulance to a skilled hospital."</p> <p>Phone interview on 11/6/13 at 4:10 p.m. with CNA B regarding resident 1 revealed:</p> <p>*Approximately 3:00 a.m. resident found with legs on floor. Was half in and half out of bed. One shoulder was on the bed and the other shoulder was on the floor. Both arms were on the floor. His</p>	F 309		

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F 309	<p>Continued From page 11</p> <p>head and the underside of his jaw was against the bar or under the bar.</p> <p>*Clear liquid all over the floor; guess it was urine.</p> <p>*His left jaw had a red indentation. It stayed that color, as there was no blood flow.</p> <p>*He never used the grab bar to help with repositioning.</p> <p>*RN C struggled to disengage the grab bar.</p> <p>*There was no documentation regarding any of the above in LPN A's nursing progress notes.</p> <p>Review of facility internal investigation report review by CNA B provided by the administrator revealed:</p> <p>*CNA B provided the information on 10/20/13 at 3:30 a.m. regarding the care of resident 1.</p> <p>**"When I was fully in the room I noticed the resident out of the right side of his bed (a grab bar was only on the left side of the bed) with the right side of his jaw hooked on the side rail of the bed."</p> <p>**"The resident's eyes were open and his skin was yellow."</p> <p>**"The first thing we did was remove the side rail from the resident's jaw, slowly lowering his head to the floor."</p> <p>*There was no documentation regarding any of the above in LPN A's nursing progress notes.</p> <p>Review of facility internal investigation report review by LPN A provided by the administrator revealed:</p> <p>*LPN A provided the information regarding the care of resident 1 on 10/19/13 through 10/20/13 between 10:00 p.m. to 6:00 a.m.</p> <p>*10:00 p.m. "Resident was being cleaned up after having a projectile emesis in bed. Out to station per wheelchair and vitals (blood pressure, pulse, and respirations) taken. Resident is afebrile (no</p>	F 309		

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F 309	<p>Continued From page 12</p> <p>temperature) and vitals within normal limits." *11:00 p.m. "Resident transferred to bed with assistance from evening nurse and writer." *12:10 a.m. "Resident resting on right side. No emesis." *1:00 a.m. "Resident incontinent of urine and small bowel movement. Cleaned up and changed. Repositioned to left side. CNA B stated resident still looks real pale (white). Resident alert by not smiling and happy self." *2:15 a.m. "Resident resting quietly on left side with eyes closed. Skin warm and dry. No emesis. Voiced no complaints." *There was no documentation of any of the above in LPN A's nursing progress notes.</p> <p>Interview on 11/7/13 at 11:00 a.m. with the DON and administrator regarding the above revealed: *It was likely due to the nature of the incident the nurses omitted to document some of the above in the medical record. *It was important that the above was documented somewhere even though it was not in the medical record.</p> <p>Review of resident 1's undated care plan revealed: **"Impaired cognitive (memory) function." **" High risk for falls. Bed in low position at night. Encourage to use call light." **"Has pressure relieving mattress on his bed." **"Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface." **"Is extensive assist of 1 to 2 staff participation to reposition or turn in bed." *The use of the grab bars or his ability to use them with bed mobility were not addressed.</p>	F 309		

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F 309	Continued From page 13 Review of a facility internal investigation report interview with licensed practical nurse (LPN) A provided by the administrator regarding resident 1 revealed: *LPN A provided the information below regarding the care of resident 1 on 10/19/13 to 10/20/13 between 10:00 p.m. and 6:00 a.m. *10:00 p.m. "Resident was being cleaned up after having a projectile (with great force) emesis (vomiting) in bed. Out to station per wheelchair and vitals taken. Resident is afebrile (no temperature) and vitals (blood pressure, pulse, and respirations) within normal limits." *11:00 p.m. "Resident transferred to bed with assistance from evening nurse and writer." *12:10 a.m. "Resident resting on right side. No emesis." *1:00 a.m. "Resident incontinent of urine and small bowel movement. Cleaned up and changed. Repositioned to left side. Certified nursing assistant (CNA) B stated resident still looks real pale (white color). Resident alert but not smiling and happy self." *2:15 a.m. "Resident resting quietly on left side with eyes closed. Skin warm and dry. No emesis. Voiced no complaints." *3:20 a.m. "CNA B entered room just ahead of writer (LPN A). CNA B turned and said [He is one the floor]. When writer got further in the room, resident was lying on his left side next to the bed. The bed was in lowest position with his neck caught on the side rail of the bed. Writer called for assistance from other staff. Registered nurse (RN) C and CNA D responded. We disengaged (took apart) the side rail and laid resident's head on a pillow. No respirations (breathing) noted and no pulse palpable (felt). Color of skin very pale and cool to touch. Resident was incontinent of urine and bowel movement. Assist of four staff	F 309		

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F 309	<p>Continued From page 14</p> <p>resident was gently rolled over on to a sheet then lifted into bed. Resident was changed and cleaned up. Director of nursing (DON) was called, police called, and hospice nurse called. Paramedics responded with police. Necessary paperwork provided to both. Hospice nurse responded. DON responded and administrator. Police questions answered and paperwork provided. Police investigation completed and autopsy requested by police. Resident's body was transferred per ambulance to a skilled hospital. DON notified family."</p> <p>3. Review of resident 1's 10/19/13 at 10:29 p.m. by licensed practical nurse (LPN) E's nursing progress notes revealed:            **Checked at 9:30 p.m. and was resting quietly in bed on his right side."            **At 10:00 p.m. certified nursing assistant (CNA) F heard unusual noise from his room and resident was found to be having projectile (forceful) emesis (vomiting). Emesis was noted to be coming out of his nares (nose) as well as mouth."            **"Was assisted up into wheelchair per Hoyer (mechanical) lift."            **"Some audible congestion noted which lessened as resident sat upright and coughed a few times. Does report feeling some better after episode. States he woke up and it hit him fast."            *Blood pressure 140/60 (normal 120/60), pulse 68 (normal 60-80), respirations 20 (normal 16-20), and temperature 98.1 (normal 98.6). Oxygen saturations 95 percent (%) (normal greater than 90 %) on room air."            *10/20/13 at 3:21 a.m. by LPN A "Resident was found on bed with head caught between grab rail and mattress. Skin pale and cool to touch. No respiration or palpable pulse. Necessary phone</p>	F 309		

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	<p>Continued From page 15</p> <p>calls and paperwork filled out with DON. Resident sent to skilled hospital per ambulance." *10/20/13 at 5:59 a.m. by the DON "Called resident's son to alert him that his dad had passed away. Told him that we found him in between the mattress and the side rail around 3:30 a.m. Told him that he had been ill during the night with vomiting. Told him that we had called the police since he was found this way and per their direction we had him taken to the morgue at a skilled hospital for an autopsy. I asked him if he had any questions and I gave him my condolences. Called administrator with an update prior to this phone call." *10/20/13 at 6:05 a.m. by LPN A "CNA B entered room at 3:20 a.m. just ahead of writer. She stated [He is on the floor]. When writer went closer resident was lying on his left side on the floor by the bed, which was in position, with his head caught on grab bar on side of bed. Resident was pale and cool to touch. No pulse palpable or respiration noted. Resident was incontinent of urine and feces (bowel movement). Writer called for assistance from other staff. Side rail was disengaged and resident's head laid on a pillow. With assist of four persons resident was gently rolled onto a sheet, and then lifted on to the bed with a sheet. Resident cleaned up and changed. DON was called. Hospice nurse called. Police called. Paramedics, police, DON, hospice nurse, and administrator responded. Police assessed situation and requested an autopsy. Body transported per ambulance to a skilled hospital."</p> <p>a. Interview on 11/6/13 at 10:00 a.m. with the DON regarding resident 1 revealed: *The DON was not an active participant in the following interviews b through l but a listener to the interviewees responses.</p>				

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F 309	<p>Continued From page 16</p> <p>*When the nurses had stated his arms were hanging she thought they meant hanging by his side and were on the floor.</p> <p>*She could not remember any education that had ever been specifically done for the staff related to the use of grab bars on the beds. Every resident had one put on their bed when the facility had opened in August 2012. No one had every really been assessed if they used them or even needed them on their bed until his death on 10/20/13.</p> <p>*She was the nurse on call on 10/19/13 and 10/20/13.</p> <p>*She was called by the facility regarding his death about 4:00 a.m. on 10/20/13 and arrived about 4:30 a.m. (lives approximately about 30 miles from facility).</p> <p>*When she got to the facility he was in bed all covered up. She did not hear the paramedics say anything unusual.</p> <p>*The paramedics were already here when I got here. I informed the family at 5:00 a.m. I told them the truth his head had been in between the grab bar on the bed and the mattress. They did not tell me they were not going to come to the facility but they did not.</p> <p>*I needed to spend a lot of my time helping the nurses as the situation was such a devastating event.</p> <p>*She could not find any documentation the physician had been informed of his condition or his death.</p> <p>b. Phone interview on 11/6/13 at 10:30 a.m. with LPN G regarding resident 1 revealed: *She came into work on 10/20/13 at 2:00 a.m. and planned to stay until 2:00 p.m. that day. It was not her usual shift but wanted to come in and see how the staff had done at night. *About between 3:00 a.m. and 4:00 a.m. CNA B</p>	F 309		

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F 309	Continued From page 17 told her she was going over to his unit to help LPN A with rounds. LPN H came and told her he had died about 15 minutes after CNA B had gotten over to the unit. *She went over there to see if they needed help calling people. The DON was called twice. The first phone call she wanted more information than just that he had died and fallen out of bed. She checked with LPN A and found out when he had fallen it was not a complete fall but had caught his head in the grab bar. That was how the staff found him and the DON was called the second time. *She only left a message for the hospice RN. She did not call the physician and was unsure who did. The family was contacted by the DON.  c. Interview on 11/6/13 at 1:30 p.m. with the administrator regarding resident 1 revealed: *He was unsure what the nurse's meant when they said his arms were hanging. *Felt the staff on duty from 10/19/13 at 10:00 p.m. through his death on 10/20/13 did not feel his projectile vomiting was a significant change in his condition and were justified in not calling the hospice RN, the physician, or his family. It was likely the vomit was on the walls because when he did vomit he was lying on his right side which faced the wall. *He was sure any formal education had been done on the use of the bed bars to the staff, but felt the staff were aware of their function and who used them. The company they had bought the beds and grab bars from promoted their use because they were not considered restraints. *After his death on 10/20/13 all residents were assessed by nursing, occupational therapy, and physical therapy for the grab bars on their beds and if they really needed them to assist the staff	F 309		

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F 309	Continued From page 18 with repositioning. Maintenance had removed some of the grab bars and had put another one on some of the beds that had been determined residents used them. Prior to that it was not felt necessary to do any type of assessments despite the warnings by the manufacturer that assessments should have been done. *He was unsure why many of the interviews and the documentation showed discrepancies. He had done interviews with the staff on duty from 10/19/13 at 10:00 p.m. through 10/20/13 at 6:00 a.m. and felt that was the accurate information. He did not think it was of crucial significance that the information he was given in his interviews with the staff was not also documented in his medical record. *The hospice administrator and hospice head RN had told him it was important to keep them updated of resident's change in conditions but not mandatory. *Hospice had put a mattress on his bed and had told him that the slippery surface of the mattress might have caused him to roll out of bed. Another hospice resident that had the same mattress as him was removed by hospice after resident 1's death on 10/20/13.  d. Phone interview on 11/6/13 at 2:00 p.m. with CNA D regarding resident 1 revealed: *She was on a different unit and was called over between 2:00 a.m. and 3:00 a.m. to help with him. *There was a lot of body fluids on the floor; unable to tell if it was urine and she was told he had projectile emesis during the night. *It took four of us to get him into bed. We changed his adult brief as it was soiled with urine and bowel movement. *LPN H and another nurse said we needed to call	F 309			

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F 309	<p>Continued From page 19</p> <p>the police. Our initial thought was to get him cleaned up to call the coroner to make him look presentable.</p> <p>e. Phone interview on 11/6/13 at 2:10 p.m. with LPN A regarding resident 1 revealed: *When she came on about 10:00 p.m. on 10/19/13 LPN E and a CNA (unsure who) were in his room with him. They didn't describe what his emesis looked like but that it had bounced off the walls. They had to put him in his wheelchair so they could change his bed and clean the walls. They put a comforter around him. LPN E said all his vitals were within normal limits. Stated he looked tough. His color was pale/grey colored. He wasn't his usual jovial self. She had worked the night before and his color was good and looked different tonight. They brought him out to the nurse's desk after they got him up. *He was at the nurse's desk a little bit and she had said how about we put him to bed. That was about 10:20 p.m. to 10:25 p.m. He was out by the nurse's station maybe about fifteen to twenty minutes. He was transferred back into bed with a Hoyer lift. They put a pad by his face in case he threw up again. They put him on his right side she believed and elevated his head a little bit. He maybe had a half smile but had no response when he was assisted back into bed. LPN E wondered if he eaten something bad with the supper meal but he was the only resident who had gotten sick. She did say he looked tough and his eyes were droopy. *She went in about 11:00 p.m. and he had his eyes closed like he was sleeping. He did not seem uncomfortable. He was dry. She did not wake him up and left him lying on his right side. The turn bar was on the left side of the bed. The call light was laying across his stomach if he</p>	F 309		

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F 309	<p>Continued From page 20</p> <p>needed it despite the fact he never used it.</p> <p>*The resident next door to him yelled most of the night and she also spent a lot of time in her room.</p> <p>*She went to his room about 12:15 a.m. and he was the same as before at 11:00 p.m. She left him on his right side until a helper came to help her turn him. He had no more emesis, appeared to be resting, and his breathing was okay with no distress. She was going between his room and the resident next door that was yelling most of the night.</p> <p>*CNA B came over at 1:00 a.m. and they changed him. He opened his eyes and did not say anything. CNA B said that he looked terrible and his color was pale grey/pasty. He was wet with urine but no bowel movement. They turned him to his left side as they turn residents only side to side at night. He did not wake up and did not look like he was feeling good. He was not himself and joking like usual. They did not check his vitals signs at that time as they had been normal earlier when LPN E had done them. They also did not want to do anything extra to aggravate him. His extremities (arms and legs) were cool to touch as usual and he did not feel febrile (with a temperature). He did not look like he was in pain. He had no mottling (blueness of extremities). His skin was dry. They thought something he had eaten had not set with him.</p> <p>*Everyone was good except him and the other resident that was yelling. About 2:00 a.m. she went back in his room to check him. He was the way we had left him earlier and had not moved at all. His color was still not good. Did not seem any different. She did not turn or reposition him since they had done that at 1:00 a.m.</p> <p>*At about 3:00 a.m. she and CNA B went into his room. CNA B was ahead of her and stated he was on the floor. His head was caught on the</p>	F 309		

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F 309	<p>Continued From page 21</p> <p>grab bar on the bed about at his Adam's apple (middle of neck). His arms were just hanging. He had slid off his bed onto the floor. He had no color and was grey. He was not moving or breathing. She sent CNA B to get help. The grab bar would not let loose so she turned his head a little bit to release pressure on his Adam's apple.</p> <p>*RN C, CNA D, and CNA B came to assist her. RN C was able to get the side rail loose. They put his head on a pillow and lowered him to the floor. They thought we needed to get him cleaned up and put back in bed. They could not feel a pulse or respirations. RN C stated that LPN G had called his family. That is why they got him off the floor but found out later LPN G had not called his family. The DON called his family about 5:00 a.m.</p> <p>*She did not make any calls. She did not know if anyone called his physician. The police were called by LPN H and were there before the DON arrived.</p> <p>*The DON had given directives that the police should be called. The paramedics arrived between 3:30 a.m. to 4:00 a.m. He was taken to the hospital between 5:00 a.m. and 5:15 a.m. His family never came.</p> <p>*The hospice nurse was not called by LPN E or her. They did not know their protocol. If something had been significant with him they would have called them. They did not think projectile vomiting was significant but only a passing bug. They did not contact the physician as they were going to watch him overnight and see if he got better. She did not take any vital signs on him. They did not call his family as they thought it was something he ate and by morning he would be better. They thought it was a 24 hour thing with him in hospice.</p> <p>*None of the other residents had experienced any vomiting after eating the taco meat and Tatar tots</p>	F 309		

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F 309	Continued From page 22 they had for supper. *No one had told her that he had three emesis. She thought he had only one emesis. She and LPN E had not discussed the need to call the hospice RN or the physician for a medication to relieve his nausea and vomiting.  f. Phone interview on 11/6/13 at 4:10 p.m. with CNA B regarding resident 1 revealed: *She was not on his unit the night of 10/20/13, but she went over to help LPN A with rounds. *They checked on him between 12:45 a.m. and 1:00 a.m. They repositioned him and changed his adult brief as it was wet with urine. They positioned him on his left side and did not remember where his call button was. She knew he did not use his call light anyway. The turn bar was on the left side of his bed. He was talking to us like he usually did, but she did not think he looked good. He looked a little bit pale. She couldn't be sure but she thought he said don't or ouch that hurts and get out of here. He normally did not like to roll on his sides. *Between 3:00 a.m. and 3:30 a.m. she went into his room. His legs were on the floor and looked like he had rolled out of bed. She called out for LPN A. Half his body was on the floor and the other half was on the bed. One shoulder was on the bed and the other shoulder was on the floor. His legs were on the floor and both his arms were on the floor. His head the underside of the jaw was not under the grab bar but against the grab bar; it is difficult to explain. LPN A tried to get his pulse. LPN A told her to get help and she got RN C. RN C said he was dead; his body and face were yellow. CNA D helped them move him. LPN A held his head and RN C moved the bed bar out of the way. They lifted him into the bed on a sheet. They cleaned him up as he was soiled of	F 309			

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F 309	<p>Continued From page 23</p> <p>urine and bowel movement. The entire floor was wet with clear liquid which she guessed was urine. They changed his pad and gown. *The paramedics and the police came in after they had cleaned him up. *She and LPN A did not hear anything in the hallway when he had rolled out of bed. His left jaw had a red indentation and stayed that color as he had no blood flow. RN C struggled to disengage the bed bar. She didn't think they ever had any education how to release the bed bars in an emergency. She thought he never had used the bed bar to aide the staff when they had repositioned him.</p> <p>g. Phone interview on 11/6/13 at 4:30 p.m. with hospice RN J regarding resident 1 revealed: *She was his primary care hospice RN and saw him at least twice weekly. *The provider had been told to call hospice with any changes in a resident's condition no matter how trivial; that would include falls, fevers, or any changes in condition. *She had never known him to have a problem with nausea or vomiting. *From 10/19/13 at 10:00 p.m. until his death on 10/20/13 at approximately 3:20 a.m. was a significant change for him. He had never had problems with vomiting before, especially projectile vomiting. The staff should have informed the hospice RN of his significant change in condition during that time frame and not waited until they found him dead.</p> <p>h. Phone interview on 11/6/13 at 4:40 p.m. with hospice RN K and the DON regarding resident 1 revealed: *They called her on 10/20/13 at about 4:00 a.m. and told her he had died. She asked them if his</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>family had been called and they told her no. They were unable to give her many details to what had happened.</p> <p>*She got there about 4:50 a.m. and the paramedics told her what had happened to him. She did not go into the room to see him but the paramedics had told her he had his head stuck in the side rail. She offered to call the family but the DON told her it would probably be better if she called them.</p> <p>*Hospice had told the staff to inform them of any change in a resident's condition; no matter how small the problem. The expectation should have been the hospice RN should have been informed about his condition at 10:00 p.m. on 10/19/13 due to his projectile vomiting, change in responsiveness, and grey colored appearance. That would have been considered a significant change in his condition.</p> <p>i. Phone interview on 11/6/13 at 5:10 p.m. with RN C regarding resident 1 revealed:</p> <p>*She was working on another unit on the night of 10/20/13. CNA B came to her about 3:00 a.m. and told her LPN A needed help as he had fallen and was unresponsive.</p> <p>*She went over to help and it was obvious he was deceased. He was not breathing, was pale, and was cold. He was on his left side on the floor. His body was on the floor except his head. His head and part of his shoulder were on the bed in between the bed and the side rail. LPN A was holding his head but she could not get the side rail down. There was urine all over. She was able to open the side rail.</p> <p>*They put a sheet on the floor and four of us moved his body into the bed. She felt for a carotid (in the neck) pulse and there was none. They all cleaned him up of bowel movement. She did</p>	F 309		

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F 309	<p>Continued From page 25</p> <p>wonder why there was urine all over the floor as he had on an adult brief. The brief was intact and was saturated with urine. The fluid all over the floor was pretty clear but it could have been vomit.</p> <p>*LPN H called the police after directed to do so by the DON. She was not sure if the physician was ever notified.</p> <p>j. Phone interview on 11/7/13 at 9:30 a.m. with CNA F regarding resident 1 revealed: *She was out by the nurse's desk about 9:00 p.m. on 10/19/13. She heard a weird voice coming from his room. *When she went into his room he was yelling at her to help him. He was half way in bed with his legs out of bed. His head was in the corner of the bed that was next to the window and he was throwing up a lot. *She yelled for LPN E to come help her. They cleaned him up and while they were cleaning him up he had two more emesis. It was a lot of emesis with chunks of food. They had to get him out of bed and put him in his wheelchair so they could clean his bed and the walls. He was very sick. *He was out by the nurse's station for a short while. They (LPN E and CNA F) put him back to bed as the next shift LPN A told them to. She had no one to help her lay him down if they left him up. *He didn't say anything when we laid him back down. His color was white and he looked like he did not feel well.</p> <p>k. Phone interview on 11/7/13 at 9:35 a.m. with CNA I regarding resident 1 revealed: *She had been working on a different unit the night of 10/19/13 but had come over to his unit</p>	F 309		

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F 309	<p>Continued From page 26</p> <p>about 9:30 p.m. to 10:00 p.m. to make sure he was okay before something else happened to him. He was up in his wheelchair at the nurse's station. LPN E did not tell her who had helped her get him out of bed; only that he had been vomiting.</p> <p>*He looked pale like he was really sick. LPN E again said he had been vomiting and did not want him to aspirate.</p> <p>I. Phone interview on 11/7/13 at 10:15 a.m. with LPN E regarding resident 1 revealed: *CNA (unidentified) from another wing walked through approximately 9:30 p.m. to 9:40 p.m. on 10/19/13 and started hollering at her to help. Resident was throwing up all over his hair, walls, floor, and bed. It was chunks of Tatar tots. It was a hard vomit. It looked like he was trying to hold his head off the bed or get his face off the bed since he was vomiting. Was trying to think what we had for supper which was tacos and Tatar tots. He ate well but drank a lot. He had no complaints after supper and took his bedtime pills okay.</p> <p>*Got him up in his wheelchair as he was at risk for aspiration and was on thickened liquids. CNA F helped get him up in the wheelchair using the Hoyer lift. They washed him up. He was pale and not retching or gagging. She figured it was a one time thing. They took him out to the nurse's desk and his vitals were ok. CNA F was going home. The resident said he was feeling good and it had hit him fast. Color was good. His color was kinda pale when they first got him up. Maybe at first his color was kinda grey or maybe pale.</p> <p>*She wanted to keep him up but the next shift wanted him put back to bed as there was no one to help LPN A lay him back down in bed. They laid him down about 11:00 p.m. (CNA F and LNP</p>	F 309		

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F 309	<p>Continued From page 27</p> <p>E). He was feeling good by then.</p> <p>*She thought he had one emesis but it could have been three emesis.</p> <p>*She did not notify his family, the physician, or the hospice nurse as she thought it was a one time thing and the taco meat disagreed with him and he had a bad tummy. Did not think notifying them was necessary as he felt better and had relief after throwing up.</p> <p>*Her gut feeling was to leave him up in the wheelchair by the nurse's station so they could keep an eye on him with his high risk of aspiration. The next shift wanted him laid down back in bed as the nurse had no one to help her lay him back down. If she had been on that shift, she would have left him up in his wheelchair. He had aspirated some time back and ended up in the hospital with pneumonia.</p> <p>*There was no documentation in LPN A ' s progress notes of any of the findings reviewed with CNA B and LPN A during the facility internal investigation.</p> <p>Interview on 11/7/13 at 11:00 a.m. with the DON and administrator regarding the lack of documentation in the progress notes of LPN A revealed:</p> <p>*It was likely due to the nature of the incident the nurse omitted to document some of the above in the medical record.</p> <p>*It was important that the above was documented somewhere even though it was not in the medical record.</p> <p>4. Review of resident 2's medical record revealed:</p> <p>*A 10/29/12 admission date.</p> <p>*Diagnoses dementia (memory loss) with behavioral disturbances and Alzheimer's disease.</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>*He had a grab bar on the left side of his bed since his admission. (Documentation below revealed grab bars removed from the bed. There was no documentation in the medical record whether he had one or two grab bars and interviews with various staff revealed no one was certain).</p> <p>Review of resident 2's 1/1/13 incident report provided to the surveyor revealed: **"Resident was found in his room sitting on the floor mat. Resident's back was up against his bed and his head was resting between the grab bar and his bed. No injuries were noted. Resident was confused with impaired memory." **"Staff followed proper safety precautions by lowering bed to floor and having floor mat next to bed. Grab bars were removed from the bed since resident does not use them during transfers." *There was no documentation the resident's safety and ability to use the grab bar/bars had been evaluated from 10/29/12 to 1/1/13.</p> <p>Review of resident 2's undated care plan revealed: **"Impaired cognitive function related to Alzheimer's disease." **" Is at high risk for falls." **"The bed in low position, floor mat next to bed, no handrails on bed, and personal items within reach." **"Totally dependent on staff for repositioning and turning in bed." *The use of the grab bars or his ability to use them with bed mobility from 10/29/12 until 1/1/13 were not addressed. (Was addressed on 1/1/13 incident report he had never been able to use them).</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>5. Interview on 11/6/13 at 1:40 p.m. with occupational therapist (OT) L regarding the use of grab bars revealed: *When the facility had opened in August 2012 all fifty-eight residents' beds had at least one grab bar on them. *OT and physical therapy (PT) had not been involved in assessing any residents if they used them or not to enhance their bed mobility until 10/20/13 with resident 1's death. *Sometimes a nurse would inform them they thought a resident needed to have two grab bars on instead of one. Maintenance would be informed and would put the second one on. *The interdisciplinary team talked about the grab bars and if a resident used them to make them more independent with bed mobility. None of the staff documented anything in the resident's medical record. *She was not aware if any education had ever been done regarding the use of the grab bars. OT and PT had never been involved in any education to the nursing staff. *After resident 1's 10/20/13 death nursing had immediately evaluated which residents had grab bars on their beds, who did not have them, and who would benefit from them on their beds. Nursing then informed social services who then informed OT and PT. Maintenance was then informed and either removed grab bars from residents' beds if they did not use them or need them or put a second grab bar on the residents' beds that needed them.</p> <p>6. Interview on 11/6/13 at 1:55 p.m. with maintenance man M regarding the grab bars revealed: *He had removed grab bars from some residents' beds and had put an additional one on others if</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>directed by the nursing staff.</p> <p>*He had thrown away all the nursing request slips from 10/20/13 through today, so he did not remember all the resident's beds he had worked on.</p> <p>7. Interview on 11/6/13 at 2:00 p.m. with the administrator regarding grab bars revealed:</p> <p>*When they had bought all the beds back in August 2012 the selling point had been the grab bars were not considered a restraint.</p> <p>*They had not done any formal assessment for each resident and did not feel that was necessary, since they were not considered a restraint but were a benefit for the resident.</p> <p>*He knew they talked to the staff about the grab bars, but no formal education or documentation had been done.</p> <p>*No one had told him the grab bars were hard to release.</p> <p>*They had not felt it necessary to assess any other residents and the use of grab bars after resident 2 had his head between the grab bar and mattress on 1/1/13. He had not been hurt. He was not sure why resident 2 even had the grab bars on his bed since he had not used them.</p> <p>*He was aware of the multiple warnings in the user manuals but all products came with warning labels. A person would never be able to use a product if they were scared off with the warnings everything came with.</p> <p>*Hospice had supplied the air mattress for resident 1's bed. He was unsure if they were aware of the manufacturer's warning to not use them unless the benefits outweighed the risks. He knew the resident had a problem with skin breakdown, so it was a benefit but was unsure if there was any specific documentation in his record reflecting that.</p>	F 309			

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F 309	Continued From page 31  8. Review of the provider's 4/6/12 Fall Prevention policy revealed: **"To provide a safe and least restrictive environment for our residents." **"A fall without injury is still a fall." **"Residents will be assessed on admission, quarterly, annually, and whenever a significant change occurs for risk factors that may place them at risk for falls." **"Residents will also be assessed after a fall to determine what risk factors if any, contributed to the fall." **"Bed bars at head of bed if resident needs them as enablers. Will not be used unless resident is able to assist with turning and positioning/transfers in bed or assisting with transfers. Lip or scoop mattress may be used if resident is leaning to edge of bed unless pressure relieving mattress is required." **"Charge nurse is to conduct an immediate investigation and follow-up in the event of a fall. Charge nurse is to use discretion regarding the need to request therapy assessment." **"Will make sure one-half rail or bed bar is locked into place before getting resident out of bed and before putting to bed." **"When deemed necessary CNAs will complete thirty minutes checks to ensure resident safety and will maintain documentation of these checks." **"Therapy will assess resident on admission and if a significant change occurs for any adaptive equipment that may be needed. As requested, will also see resident if a change in present interventions is warranted." **"Care plans will be reviewed and interventions revised/added after a fall." **"The facility resident safety committee will review	F 309			

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F 309	Continued From page 32 all falls and will recommend measures to prevent future falls. They will also review all residents identified at high risk for falls for prevention planning."	F 309			
F 323 SS=G	9. Review of the provider's revised August 2013 Resident Safety Committee policy revealed: **"To identify problem areas of concern with residents." **"To eliminate or reduce the areas of concern through education of staff and/or residents." 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: Surveyor: 22452 Based on record review, interview, policy review, and product user-service manuals for the use of the bed frames and assist bed handles, the provider failed to assess and monitor the use of the the assist bed handles for two of two sampled residents (1 and 2). Findings include:  1. Review of an undated product user-service manual for Joerns bed frames (type used on the residents' beds) revealed: **"Residents/patients may become entangled in pendant cord. Residents/patients with reduced	F 323	F 323  The facility ensures 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  1. Resident # 1 is no longer a Resident of the facility.  Resident # 2's use of / need for grab bars for bed mobility was assessed and the Comprehensive Plan of Care updated by the Interdisciplinary Team on 1/02/13. The Resident and Responsible Party was informed of the care plan update on 1/02/13. See F 280  All residents who use Grab Bars/ Bed Rails for Bed Mobility are at risk.  2. The User Service Manual for Joerns bed frames used for our residents was reviewed by the QAA Committee on 12/2/13 and the safety warnings used to update the Bedrail and Fall Policies.	12/07/13	

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F 323	Continued From page 33 mental acuity should not be allowed access to pendant. Unsupervised use of pendant could result in injury or death." **"Use a mattress that is properly sized to fit mattress deck, that will remain centered on mattress deck relative to state and federal guidelines. Joerns Healthcare recommends the use of a mattress with minimum dimensions of 35 inches wide and 6 inches deep. Length should match mattress support platform. Use of an improperly fitted mattress could result in injury or death." **"If a resident/patient's mental or physical condition could lead to a resident/patient entrapment, the mattress support platform should be left in the flat position when unattended. Failure to do so could result in injury or death." **"An optimal bed system assessment should be conducted on each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance." **"Use a properly sized mattress in order to minimize the gap between the side of the mattress and assist device. This gap must be small enough to prevent resident/patient from getting his/her head or neck caught in this location. Make sure that raising or lowering bed, or contouring the sleep surface, does not create any hazardous gaps. Excessive gaps may result in injury or death." **"Locate mounting brackets for assist devices strictly according to instructions. Gap between head/foot panel and assist device must be small enough or large enough to prevent resident/patient from getting his/her neck caught	F 323	F323 Contd.  All Staff were in-serviced on 12/2-6/13 on the Updated Bed Rail Policy and Fall Policy by the DNS.  The Use of alternating air mattresses was reviewed by the QAA Team on 12/2/13 and the Team decided the risk of this device outweighs the benefit. A policy was drafted and approved. All Staff were educated by the DNS on 12/2-6/13 on the decision to not utilize alternating air mattresses in the facility and the effective alternative.  Per the Directed In-Service Training the DNS educated All Staff on Incident Reporting- and the requirement for clear, concise, accurate documentation on 12/2-6/13.  Per the Directed In-Service Training the DNS educated All Staff on 12/2-6/13 on Identifying safety, accident hazards - reviewing use of equipment and potential hazards specifically Bed Bars, Facility Joerns Beds, and Specialty Pressure Reduction Mattresses/Overlays such as the Invacare Alternating Air Mattresses.		

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F 323	Continued From page 34 in this location. If multiple assist devices are used, position each so that gap between them is large enough for trunk and hips to pass through easily. Make sure raising or lowering bed, or contouring sleep surface does not create any hazardous gaps. Failure to do so could result in injury or death." **"Powered air mattress surfaces may pose a risk of entrapment. Prior to use, ensure the therapeutic benefits outweigh the risk of entrapment." **"The assist device is intended for use as an aid in entering or exiting the bed sleep area, as well as a stable handhold during self-positioning within the bed sleep area." **"Proper combinations of bed, mattress, head/foot panels, and assist devices are needed to minimize the risk of entrapment."  2. Review of resident 1's 10/7/13 and 10/20/13 incident reports provided to the surveyor revealed: *10/7/13: -"Writer heard a noise and went to go check on resident. Found resident with legs and torso (upper body) on the floor next to his bed wrapped up in his blankets. Resident's head was still partially on the bed. Resident assisted back into bed via Hoyer lift. Resident noted to have obtained a 1 centimeter (cm) by 1.8 cm skin tear on right elbow. Resident oriented to person but confused. Was lying on left side facing away from the wall. Was found laying on right side facing the wall." -"Staff instructed not to have resident propped on too many pillows to be sure he does not roll off easily. If we prop resident with pillow, prop on right side so he is facing the wall and will not roll off bed. Instructed to do frequent rounds on	F 323	F323 Contd.  3. Compliance with the recommendations in the Joerns bed frame manual, the Policy and Procedure for use of Grab Bars inclusive of the risk for entrapment, discontinuing the use of alternating air mattresses in our facility, Incident Reporting and the requirement for clear, concise documentation, and identifying safety/accident hazards will be monitored by the DNS or designee weekly X12 and monthly thereafter.  4. The results of this monitoring will be reported to the facility QAA Committee monthly for review and recommendations for further action. DNS or Designee Responsible	

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F 323	Continued From page 35 resident when in bed." *10/20/13: -"CNA B entered resident's room just ahead of writer (licensed practical nurse A). CNA B stated he was on the floor. He was on his left side on the floor beside the bed, which was in lowest position with his neck caught at the Adam's apple (neck) on the grab rail of the bed. Resident was pale in color and skin cool to touch. No pulse palpable or respiration noted." -"Writer tried to move resident's head to see if airway could be opened. Resident's body weight pulled making it impossible to release resident's head completely. Writer unable with resident's head pulling at grab bar to get grab bar to release. Help arrived and grab rail released and resident's head placed on a pillow on the floor. Resident had been drowsy with impaired memory." -10/22/13 addendum- "This report filed late due to writer (LPN A) and director of nursing not knowing it was required with previous paperwork submitted." -10/29/13 addendum- "Resident ill earlier in the evening and being checked frequently by nursing staff. Currently receiving hospice services. Checked on at approximately 2:15 a.m. and noted to be resting quietly in bed. At 3:30 a.m. staff entered room to find him half on the bed and half on the floor. His head was noted to be against the deluxe assist handle and his back against the mattress going down towards the floor. Staff unable to find a pulse. Body taken to morgue." *Police investigation closed on 10/21/13 as coroner's office had completed a medical examination and determined cause of death accidental positional asphyxiation. Provider notified Food Drug Administration (FDA) and	F 323			

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F 323	<p>Continued From page 36</p> <p>manufacturers of incident. Provider evaluated all beds with deluxe assist handles.</p> <p>Review of the 10/24/13 FDA report regarding resident 1 revealed: *Adverse event of death on 10/20/13. **"About 3:00 a.m. a certified nursing assistant and a nurse found resident one-half on floor with his head still on bed between mattress and assist bar. The resident was not responsive and had expired." ***Resident had been ill/vomited earlier in evening. Receiving hospice services since 5/29/13. Medical diagnoses pneumonitis due to inhalation of food, chronic kidney disease, and dementia (memory loss)." ***Suspect products Joerns Deluxe Assist Handle and Invacare Alternating Pressure Mattress."</p> <p>3. Review of resident 2's medical record revealed: *A 10/29/12 admission date. *Diagnoses dementia (memory loss) with behavioral disturbances and Alzheimer's disease.</p> <p>Review of resident 2's 1/1/13 incident report provided to the surveyor revealed: **"Resident was found in his room sitting on the floor mat. Resident's back was up against his bed and his head was resting between the grab bar and his bed. No injuries were noted. Resident was confused with impaired memory." ***Staff followed proper safety precautions by lowering bed to floor and having floor mat next to bed. Grab bars were removed from the bed since resident does not use them during transfers."</p> <p>4. Interview on 11/6/13 at 1:40 p.m. with occupational therapist (OT) L regarding the use of</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>grab bars revealed:</p> <p>*When the facility opened in August 2012 all fifty-eight resident beds had at least one grab bar on them.</p> <p>*OT and physical therapy (PT) had not been involved in assessing any residents if they used them or not to enhance their bed mobility until 10/20/13 with resident 1's death.</p> <p>*Sometimes a nurse would inform them they thought a resident needed to have two grab bars on instead of one. Maintenance would be informed and would put the second one on.</p> <p>*The interdisciplinary team talked about the grab bars and if a resident used them to make them more independent with bed mobility. None of the staff documented anything in the resident's medical record.</p> <p>*She was not aware if any education had ever been done regarding the use of the grab bars. OT and PT had never been involved in any education to the nursing staff.</p> <p>*After resident 1's 10/20/13 death, nursing immediately evaluated what residents had grab bars on their bed, who did not have them, and who would benefit from them on their bed. Nursing then informed social services who then informed OT and PT. Maintenance was then informed and either removed grab bars from residents' beds if they did not use them or need them or put a second grab bar on the residents' beds that needed them.</p> <p>Interview on 11/6/13 at 1:55 p.m. with maintenance man M regarding the grab bars revealed:</p> <p>*He had removed grab bars from some residents' beds and put an additional one on others if directed by the nursing staff.</p> <p>*He had thrown away all the nursing request slips</p>	F 323		

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F 323	Continued From page 38 from 10/20/13 through today, so he did not remember all the resident's beds he had worked on.  Interview on 11/6/13 at 2:00 p.m. with the administrator regarding grab bars revealed: *When they had bought all the beds back in August 2012 the selling point had been the grab bars were not considered a restraint. *They had not done any formal assessment for each resident and did not feel that was necessary, since they were not considered a restraint but were a benefit for the resident. *He knew they talked to the staff about the grab bars, but no formal education or documentation had been done. *No one had told him the grab bars were hard to release. *They had not felt it necessary to assess any other residents and the use of grab bars after resident 2 had his head between the grab bar and mattress on 1/1/13. He had not been hurt. He was not sure why resident 2 even had the grab bars on his bed since he had not used them. *He was aware of the multiple warnings in the user manuals, but all products came with warning labels. A person would never be able to use a product if they were scared off with the warnings everything came with. *Hospice had supplied the air mattress for resident 1's bed. He was unsure if they were aware of the manufacturer's warning to not use them unless the benefits outweighed the risks. He knew he had a problem with skin breakdown so it was a benefit but was unsure if there was any specific documentation in his record reflecting that.  Review of two handwritten sheets given to the	F 323			

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F 323	Continued From page 39 surveyor by the administrator revealed: *The handwritten sheets had no dates and were titled "Nursing evaluations" and "Therapy evaluations." *All fifty-eight residents were evaluated for their ability to use the grab bars on their beds after the death of resident 1 on 10/20/13. *Ten residents had no grab bars on their beds. There was no documentation regarding when those grab bars had been removed from their beds. Maintenance had removed them sometime between August 2012 and October 2013. He had no records of what residents he had removed the grab bars from their beds or when they had been removed. *Four residents were assessed to have grab bars on their beds that they did not use. *One resident was assessed "Not sure if uses." *One resident was assessed "Has but never in her bed." *One resident was assessed "Probably does not need them." *One resident was assessed "Has two but only needs one."	F 323			