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F 324	Continued From page 20 think they had one on her and she took it off." There are 7 residents who reside on the same wing as the dietary department. 1 of the 7 is identified by the facility as cognitively impaired (R4).	F 324		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.1210a) 300.1210b)6) 300.1220b)3 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	F9999		

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F9999	Continued From page 21 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview and record review in the area of side rail use, the facility neglected to assess for their use, identify risks to the resident, implement care plan approaches to prevent injury, and maintain side rails in a safe manner that would reduce accident hazards by not correcting loose fitting, movable rails and gaps. This neglect began on 10/3/06 when R1 was moved to another room and placed in a bed which allowed her to put her legs through the side rails. R1 became entrapped in the side rails on 10/10/06 which required extrication by 2 persons. R1 sustained a partial thickness	F9999		

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traumatic wound to the right lower leg from just below the knee to the ankle as a result of struggling to free herself from the rails. This applies to residents who have full side rails, 1 of 3 residents in the sample (R1).

The facility also neglected to develop fall prevention approaches, analyze patterns of resident falls, have staff knowledgeable of which residents were at risk for falls, ensure residents identified at high risks for falls were provided assistance when transferring and toileting, and provide adequate supervision and monitoring of residents at risk for falls. This neglect resulted in R2 sustaining a traumatic amputation of the left index finger on 10/23/2006 after taking herself to the bathroom. It also resulted R3 sustaining a head laceration requiring 6 staples to close the wound after ambulating independently in her room. on 11/15/06. R3 had 11 documented falls between 10/31/06 and 11/15/06.

The examples include:

1. R1's side rail assessment of 10/23/06, completed after R1 became entrapped in the side rail on 10/10/06, does not document or analyze the risk factors associated with the use of side rails. R1's care plan dated through 1/7/06 does not identify the use of side rails or R1's history of entrapment in the side rails. There were no approaches to prevent further injury to R1 associated with side rail use.

R1's November, 2006 Physician's Order Sheet documents that R1's diagnoses include Severe Degenerative Arthritis, Dementia with Behavioral Disturbance, and Osteoarthritis. Review of R1's

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assessment of 11/6/06 assessed R1 to have short and long term memory problems with moderate impairment in cognitive skills. R1 was assessed to require extensive assistance of one person for bed mobility and transfer. The assessment shows that R1 had a fall in the last 30 days and used 2 full bed rails on all open sides of the bed.

The facility Incident/Accident Report of 10/10/06 documents that R1 was found with both legs between side rail and mattress, touching floor. R1 was tightly wedged in and a 10 centimeter (cm) blood spill was present. R1 "see-sawed" her legs back and forth against the metal bed frame and the bottom side rail. The Nursing Note written by E3 (RN) dated 10/10/06 at 3:00 AM documents the following, "called to resident room by Certified Nursing Assistant (CNA) both of R1's legs between mattress and side rail (side rail metal) legs touching floor. R1 was drawing legs back and forth and side to side. There was a pool of blood approximately 10 cm round. R1 was removed from the side rails carefully as she was wedged tightly. An ambulance was notified to transport R1 to the hospital."

The hospital Physician Progress Note of 10/21/06 documents that R1 had a wound on her right leg. The right leg wound was found to be infected with MRSA (Methicillin Resistant Staphylococcus Aureus). The same documents shows that R1 was to be referred to Plastic Surgeon regarding the wound on her right leg.

The facility Side Rail Assessment dated 10/23/06 shows no analysis of R1's risk factors related to the use of side rails. Item number 15) states "Do the side rail alternatives/interventions create

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F9999	Continued From page 24 more risks than side rail use?" The response to the question is checked as "yes, due to Dementia with Behavioral Disturbances." E2 Director of Nursing (DON) was interviewed on 11/20/06 at 2:00 PM regarding R1's incident. E2 said I will need to go check the record first. E2 said that R1 was in another room and her bed was against the wall. E2 said R1 would lay in a fetal position on her left side and put her legs out. When R1 was moved to another room, she put her leg through the side rail and pulled it in and out scraping her leg. Since, we have had to make the mattress so tight she could not get her leg free. E2 said she was bothered by this. E2 was asked if there was a documented investigation of R1's incident. E2 said the information she had was what she had been told. E2 did not offer any further information related to R1's incident. On 11/20/06 at 1:10 PM, R1 was observed with E7(Licensed Practical Nurse). E7 unwrapped an ace bandage from R1's right leg. R1 had a linear open wound from just below the knee and extended to just above the ankle. E7 said she was told that R1 had scraped her leg on the side rail. R1 did not respond during the observation. E1 (Administrator) was interviewed on 11/20/06 at 12:35 PM. E1 said that many of the side rails were removed but they just keep cropping up again. The facility policy entitled Side Rails shows under the section of Practice, item C: "The restraint is to be care planned with directions for when to use, monitoring, and restraint reduction. Item number 3. documents: "When side rails are used to facilitate mobility in and out of bed, side rails do not meet the definition of a restraint. Side rails used in the facility that do no meet the	F9999		

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F9999	Continued From page 25 definition of restraints per the side rail assessment will be care planned as such." E3, Registered Nurse (RN), was interviewed on 11/28/06 at 8:30 AM. E3 said that when she was called to go to R1's room, "R1(was) laying across the middle of the bed, her feet were in between the bottom of the side rail and the mattress. R1's legs were touching the floor. R1 had been bringing her knees back and forth, the rail was pretty sharp, very sharp actually, and the mattress was very tight. E3 said she called downstairs to get some help, R1's legs were pretty scraped up. I do not remember if I called 911 or an ambulance. R1 went to the emergency room and I assume she was admitted." On 11/28/06 E8 Certified Nursing Assistant (CNA) was interviewed at 8:05 AM. E8 said that when she made rounds at 12:45 AM she saw R1's legs wedged between the bottom of the side rail and the mattress. E8 said she got E3 to help me get her out. E8 said "I let the side rail down on the other side of the bed and pulled the mattress over so we could get her out, then 911 was on the scene. R1 always favored her left side. I had brought it to the nurse's attention that maybe they could put her bed against the wall. We had to clean up R1's leg because it was bleeding." E4 was interviewed on 11/28/06 at 12:40 PM. E4 said that she did go to the center with R1 and was asked what happened to R1. E4 said I told them that R1's wounds were from an accident with the side rails. E5 (Activity/Social work Designee) was interviewed on 11/28/06 at 12:35 PM. E5 said	F9999		

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F9999	Continued From page 26 that R1 was moved into her new room (201) on 10/2306. R1 was moved to the first floor when she returned from the hospital (10/23/06) to the Medicare Section. The problems and approaches on R1's Care Plan dated through 1/7/06 do not include the use of side rails, the risk factors associated with the use of side rails, or any approaches to ensure R1's safety with the use of side rails. On 11/27/06 observations were made of all the facility beds. There were 28 beds out of 97 beds that had full side rails on both sides of the bed. The following rooms were found with loose fitting/wobbly rails: West 201 Bed A which also had a gap of 11 inches from the head board to the start of the side rail. East 108, 112, 113, 201 all had loose/ wobbly side rails. The type of rails on all the beds observed (excluding 107) had 5 1/2 inches between side rail slats. 2. On 10/23/06 R2, who is identified as high risk for falls, took herself to the bathroom unassisted. R2 lost her balance, grabbed onto the room door to the hallway which slammed shut on her finger. R2's left index finger was traumatically amputated by the force of the door slamming on her finger. Review of the facility policy entitled Fall Prevention documents under Policy: All residents that are assessed as risk for falling will have interventions and approaches placed on a Care Plan directed towards reducing falls. Under the Interventions section item 5) documents "Assist with Activities of Daily Living (ADLs) and take to the bathroom as needed. Item 7) Alarm device on chair or bed as needed. Review of R2's entire Care Plan dated through November, 2006 shows	F9999		

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F9999	Continued From page 27 no Fall Risk Identification or fall prevention measures. The Minimum Data Set of 11/4/06 lists R2's diagnoses to include Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Cardiac Dysrhythmias. It documents that R2 has no short or long term memory problems and is independent in her decision making abilities. She requires supervision of one for toileting , limited assistance of one for transfers and has an unsteady balance when standing. The Fall Risk Assessment dated 10/10/06 scores R2 as a 10 (Score of 10 or above represents High Risk). The medical record contained no evaluation to determine if the use of a chair or bed alarm device would benefit R2. R2 had no alarm device in place at the time of the fall. The Physical Therapy Assessment dated 10/12/06 documents R2 to have general weakness, decreased balance and coordination, decreased endurance resulting in decreased safety with transfers and ambulation. An Incident Report dated 10/23/06 at 11:15 PM documents R2 was was last seen sitting in her wheelchair in her room after receiving her antianxiety medication. "I had just stopped outside the door of room W132- I heard some pounding and saw the 1East/1West nurse walking towards 1East room 106/104 - she thought at first the pounding was from 106 - but then when it sounded again she knew 106 was the wrong room. She went up to room 104 and opened the door and I heard her then say 'Oh, my God!' R2 was on the floor with blood on her and the floor." Staff noticed the tip of her left	F9999		

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F9999	Continued From page 28 pointer finger was off and then found the tip of her finger on the floor near her right shoulder." Specifications of the door that caused the injury, include that the door is 43 3/4 inches by 79 1/4 inches by 1 3/4 inches thick, weighs 134 pounds and is a fire door. The door was observed on 11/29/06 and was heavy to move. On 11/20/06 at 1:45 PM, E2, Director of Nursing stated, "They said they found her in the bathroom laying on the floor. She must have had her finger up by the door. People think she is alert but she is confused at times. She toilets herself with assistance. We check on her." On 11/20/06 at 1:00 PM R2 stated, "I came because I was falling at home. I came from the bathroom, I locked my walker and I must have lost my balance and I grabbed the door. Then the next thing I remember I woke up on the floor. I started pounding on the door and calling for help." R2 was asked if she had her call light on. R2 replied, "They come in if they feel like it. That's all I can tell you Honey, that's all I know." On 11/20/06 at 2:45 PM, CNA staff was asked how they know what residents are at risk for falls. E12 (CNA) stated, "If they are stumbly, especially on transfers. I guess you keep a watch on them. It depends on how bad they are, sometimes every 15 minutes, sometimes every hour, sometimes 2 hours. We report to the nurse if we see something, then it is up to her." E13 (Rehab CNA) stated, "I work in rehab. All I do is if we know someone is at risk to fall we let therapy know so they can be screened for therapy." E14 (CNA) replied, "Usually by their ability to stand. Use our own judgement." E15(CNA) stated, "In	F9999		

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F9999	Continued From page 29 report or if they are having any problems." and E16 (CNA) stated, "Basically from report, new residents, the nurse, the residents with alarms." None of these staff included comments about risk for falling being on the assignment sheets. E2 Director of Nursing was interviewed on 11/20/06 at 3:05 PM. E2 said that staff know who is at risk for falls because they get report from the nurses. On 11/29/06 at 2:35 PM Z4 (Physician) stated, "(R2) amputated the finger transversely. It looked like a guillotine had chopped it off. The bone was sticking out the top." Z4 was asked about the kind of force it would take to amputate a finger in this way. Z4 replied, "It would have to be something of significant force and very sharp. Like two pieces of metal coming together." Z4 was asked if a door closing could have caused the amputation. Z4 stated, "If it was in the door jam that is a reasonable assumption." The facility policy entitled Fall Prevention states "Any resident requiring assistance is considered as risk and will be addressed on assignment sheet", "Assist with ADLs and take to bathroom as needed",and "Alarm device on chair or bed as needed". R2's care plan dated 10/25/06 identified no risk for falls, nor were fall prevention approaches developed. 3. R3 was identified as being at high risk for falls. R3 experienced 11 falls between 10/31/06 and 11/15/06 (15 days). On the eleventh fall (11/15/06) R3 sustained a head injury requiring 6 staples to close the wound. R3's plan of care to	F9999		

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prevent falls did not occur until after R3 sustained the head injury.

The assessment of 11/9/06 lists R3's diagnoses to include Dementia, Anxiety, Depression and Seizure Disorder. It documents that R3 has short term memory problems, moderately impaired decision making ability and requires the supervision of 1 to walk in room.

The Fall Risk Assessment dated 8/14/06 and 11/5/06 lists R3 as an 18 (Score 10 or above represents High Risk). From 10/31/06-11/15/06, R3 has eleven documented falls. Each fall occurred when R3 was alone in her room. After the first fall, the intervention was to "educate resident not to sit so close to the edge of her bed or chair." No interventions were added after the second or third fall. After the forth fall orders were obtained for "Physical Therapy evaluation and treatment to strengthen quads". No interventions were added after the fifth fall. Following the sixth fall, the Incident Report dated 11/9/06 documents that "resident has been educated over and over, alarms tried and removing walker and commode. Promote safe environment for resident." The Incident Report for the seventh fall dated 11/10/06 documents "Resident seems to get alone and no matter what does not seem to use the call light even though she knows." Interventions were added to "put resident in front of nurses station, keep a close eye on her, and take to dining room during meals." After the eighth fall on 11/11//06 the Incident Report states "on floor AM shift, PM shift, Night shift. Maybe she needs an alarm or (rolling ambulation device)." No interventions were listed on this report. No interventions were added after the ninth fall. After the tenth fall, the Incident Report

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F9999	Continued From page 31 dated 11/12/06 states "Resident continuously attempts to stand even after constant reminders to use call light for help. Husband requested commode and walker to be removed from room to aid in self ambulation," and "20 minute check on resident still finds resident attempted to get up out of recliner." "Remove commode and walker." Incident reports for 11/15 and 11/16/06 document on 11/15, R3 was alone in her room, self-ambulated to the closet and fell. R3 sustained a head laceration. R3 was sent to the emergency room and required 6 staples over her left eye. On 11/27/06 at 10:25 AM, R3 was observed in her room, asleep in her recliner. A soft waist restraint was loosely applied around R3's breasts. On 11/27/06 at 10:30 AM, E6 (CNA) stated, "I know we just recently put a restraint on her, she keeps getting up and falling. We check her every 15 minutes." E6 was asked if R3 was ambulatory. E6 stated that she used to be but "she is getting weaker". On 11/27/06 at 11:05 AM, Z1 stated "She (R3) is getting better physically, mentally she is not." Z1 agreed that R3 is unable to follow directions. (A)	F9999		