STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. BUILDING _____ B. WING _____	C 06/07/2007

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F 323	Continued From page 14 checked for proper functioning on May 7th and May 8th, 2007. 3. Staff was inserviced on May 7, 2007 for immediate reporting of any possibly malfunctioning equipment, removing any suspected malfunctioning equipment from resident use and filling out appropriate maintenance work orders. 4. A Formalized Preventative Maintenance Policy and Procedure for Wheelchairs/(Geriatric)chairs was implemented, originally written 5-30-07 and revised 5-31-07. 5. A Formalized Preventative Maintenance checklist for Wheelchairs/ (Geriatric) chairs was implemented on 5/30/07. 6. The Maintenance Department was in-serviced on 5-30-07 on Preventative Maintenance for geriatric chairs per manufacturer guidelines.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)6) 300.2210a) 300.2210b)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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	F9999		

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F9999	Continued From page 15 and assistance to prevent accidents. Section 300.2210 Maintenance a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. b) Each facility shall: 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to maintain a multi-position chair in a safe functioning condition for 1 of 4 sampled residents (R3). The facility failed to ensure that the reclining geriatric chair was correctly evaluated following staff concerns, and on an ongoing basis. These failures resulted in R3 being placed in an improperly maintained chair and subsequently sustaining an avoidable fall with injuries. R3 sustained an intracranial hemorrhage and a subdural hematoma resulting in death. Findings include: According to R3's May 2007 Physician's Order Sheet (POS) the current diagnosis included Cardio Vascular Accident with Left Side Hemiplegia. The POS lists an admission date of 4-24-07 and doctor's orders for anticoagulant therapy, Skilled Therapy Services, Speech	F9999		

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F9999	Continued From page 16 Therapy, Physical Therapy, and Occupational Therapy. The facility's Care Plan dated 4-30-07 lists R3's height at 72 inches (6 feet) and weight of 245 pounds on admission. The facility's Quality Care Reporting Form completed by E2, Director of Nursing (DON), shows that R3 was found on the floor on 5-7-07 at 1:15pm in the resident's room with a hematoma of 1 centimeter to the left side of the head above the eye brow. Staff cleaned the wound, applied steri-strips and ice for the bleeding, and completed notification of the Physician and family. When the ambulance arrived R3 was transported to the Emergency Department of a local hospital and later admitted. The Coroner's Preliminary Death Report dated May 8, 2007 was submitted by Z4, County Coroner. On 6-1-07 at 11:15am Z4 verified that the final diagnosis for cause of death was "Intra Cranial Hemorrhage Subdural Hematoma Blunt Force Trauma due to a fall from a chair with a contributing factor of Coumadin usage." Z4 explained that he had spoken with R3's doctor and that with the high level of coumadin in the system, you will bleed and they could not control the bleed. Z6, Neurologist for R3 during hospitalization after the fall on 5-7-07 was interviewed on 6-6-07 at 2:00pm. Z6 verified the cause of death that was written in the Coroner's Report and stated R3 had an "Intra Cranial Hemorrhage due to the blood thinning, he had a trauma that caused the bleed, and he continued to bleed until you correct the medication level, which in this case is Coumadin." When asked in your professional	F9999		

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F9999	Continued From page 17 opinion could there be any other cause of death, Z6 stated "(Z6) don't believe so, no other cause of death." Z6 continued "(R3) had a massive stroke prior to the nursing home . . . around April 9, . . . (R3) was not a healthy guy, no way to reverse the outcome with all the medical issues." E2, Director of Nurses, (DON) was interviewed at 1:30pm on 5-24-07 about R3's fall from the reclined geriatric chair on 5-7-07. E2 stated she saw Z1, Certified Occupational Therapy Assistant (COTA), taking R3 back down the hall in the reclined geriatric chair to R3's room after therapy. E2 stated "(R3's) geriatric chair was in the reclined position earlier during transport, and when (R3) was found to have fallen on the floor the geriatric chair was in a fully upright position." E2 stated "he was facing away from the chair, his feet were to the chair and on his stomach." E2 continued with describing R3's injuries, "I saw a hematoma and a laceration, (pointing to an area above the left eyebrow)." E2 described an area of blood on the floor by R3's head. E2 stated that R3 was asking for her to get him off the floor. E2 stated staff called the Doctor and R3 was transported by ambulance to the hospital. E5, CNA was interviewed on 5-29-07 at 12:10pm regarding R3's fall on 5-7-07. E5 stated "I would check on (R3), normally only up for therapy - I would check on him every time I would walk by if the curtain wasn't pulled." E5 explained "(R3) was antsy in bed. He was fidgety in bed. Moving his good leg around in bed. Wiggling himself down in bed. In the Chair- I could tell the difference he pretty much just sat there. We just got him up and took him to therapy. Got him up 9:30am to 10:30am usually. It had been later - it depends when therapy was ready for him." On	F9999		

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5-7-07 E5 recalled last checking R3's room around 11:30am and since R3 wasn't back yet, E5 continued taking residents to the dining room. E5 stated "(E4) was also working down that hall, (E4) was not back from her break yet."

E4, CNA, was interviewed at 11:25am on 5-29-07. E4 confirmed that R3 stayed in bed except for the time that R3 was taken in the reclined geriatric chair to therapy one time per day. E4 stated "when in bed (R3) moved around a lot - we would go in periodically every hour to check to see if (R3) was near the rails or kicked his covers off. In his chair (R3) was in therapy. We would go by the room to see if (R3) was in there. Therapy would let us know that (R3) was back. I checked on (R3) at 5 til 12(noon) and I checked on him and (R3) was fine and (R3) was sitting back in the chair and resting. It (tube feeding) was disconnected. (R3) was asleep in the chair. I was getting the rest of the residents up for dinner. We would have needed to go get the mechanical lift (to do the transfer)." E4 went out to the dining room to feed. The next time E4 saw R3 was when they found him on the floor. The position of the chair as identified by E4 when she went into the room after R3 had fallen on the floor was "the foot rest was straight down." E4 stated during this interview, "I have never seen (R3) move in that chair he usually lays and relaxes. (R3) (gets) worked up when in bed if the sheet is bothering him, or if he needed changed."

E5, CNA, was interviewed on 5-29-07 at 12:10pm E5 stated "they paged for the 200 hall CNA's to return to the 200 hall on (5-7-07 at approximately 1:15pm)." When asked what E5 noticed in R3's room, E5 stated, "the foot rest was down (so the chair was in the upright position), the tube

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feeding was not connected, (R3's) geriatric chair was located between the two beds, (R3) was laying on (R3's) stomach at a slight angle with (R3's) head toward the left. (R3's) shirt was off over the top of his head and his arms were still in his shirt , his head was out of it. . (pointing to an area across the top of E5's upper chest/neck area) . . . . His clothes are loose, but (R3) could take off the gown in bed. The only time (R3) had clothes on was to get up. (R3) was a big guy."

E7, CNA, was interviewed on 5-29-07 at 1:10pm about the fall R3 had on 5-7-07. E7 stated "(E7) went to see if they needed an extra hand when they paged to 200 hall. (R3) was face down, and face turned a little, . . . (R3's) shirt over his head his arms still in the shirt."

Interview with Z1, Certified Occupational Therapy Assistant (COTA), on 5-29-07 at 9:30am showed that R3 was able to follow simple one step directions in therapy, but had left side neglect "really bad." When asked about R3's movements in the geriatric chair, Z1 stated "usually laid him flat on his back in the chair without using any pillows to position. This particular day he seems to be more lethargic . When doing the floor mat exercises was more slumped and was more fatigued."

Z2, Physical Therapy Assistant/Certified (PTA/C), was interviewed on 5-29-07 at 10:25am. When describing R3's sitting balance during the therapy session on 5-7-07, Z2 stated, "I was holding (R3) up a lot, he was unable to do this, I was holding him up, (R3 was) very flaccid on the affected side - back and to the affected side."

On the Weekly Progress Notes form dated 5-1-07

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written by Z1 the number one goal was for R3 to "tolerate sitting up in (wheel chair). . ." with the previous week status R3 was bed bound and the current status listed as "sits in (geriatric chair) with back reclined...." Under goal number 5 appropriate wheel chair cushion for optimal posture, the current status for R3 was "(geriatric chair) with chair in reclining position when unsupervised." Z1's Weekly Progress Notes dated 5-7-07 state, "the current status for sitting on the floor mat was for maximum assist of 1 to remain in the upright position."

According to the documentation on the Weekly Progress Notes form dated 5-2-07 and signed by Z2, PTA/C, R3 was beginning to track more with his eyes and was reaching toward the left side for the cones with moderate cues from Z2 or Z1 who was assisting. Z2 stated that the note written on 5-8-07 actually ended on 5-7-07 the last day that R3 was at the facility. The note stated "patient requires (maximum) of 1 on edge of mat to sit upright for sitting (balance) tasks." On the Functional Assessment section of the form dated 5-8-07 Z2 explained what was meant by "grade." Z2, during the interview at 10:25am on 5-29-07 explained, "this is talking about the muscle grade. 5 out of 5 is normal and 4 is good with moderate resistance. For (R3) the right side is 4 out of 5 and the left side is 0. There is some twitching." When asked if R3 was ever observed being restless in the geriatric chair while waiting for therapy to begin, Z2 stated "once (R3) was in the (geriatric chair) and kept moving (R3's) good leg up an down, no reason, maybe back pain, possibly."

R3's Care Plan dated 4-30-07 identified R3 as a high fall risk with one of the approaches "staff to

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monitor for unsafe behaviors." The Behavior assessment dated 5-1-07 included the following comments that led the staff to decide to continue to proceed to care plan. "(R3) resists positioning. (R3) become dissatisfied when positioned. Resisting. (R3) is restless. (R3) moves his right arm and leg. (R3) can fidget, and remove a gown. Reminders are required to utilize privacy curtains or blankets. (R3) can fidget until nude in bed. . ."

E5, CNA, was interviewed on 5-29-07 at 12:10pm about the reclining geriatric chair that was used for R3. E5 stated "I had trouble with the (geriatric chair) not staying locked with a lady we had in it before. And if she would move her feet a certain way it would go down." E5 identified this resident as R14, using this specific blue reclining geriatric chair. Further interview with E5 on 5-31-07 at 9:45am explained, "the chair back was slowly reclining more on it's own . . . didn't remember what we did with the chair or the maintenance request." E5 demonstrated how E5 would put her hand on the back of the geriatric chair to check to be sure the back was solid and holding. E5 stated that she thought E7 and E8 also knew about the geriatric chair when R14 had the chair.

E8, CNA, stated on 5-30-07 at 9:35am "it (the geriatric chair) would lock real good for a week or two. Then it would go to Maintenance and eventually it would fail again. We had 2 blue (reclining geriatric chairs) just alike. You would put (R14) in it and touch the back of the chair and it would slowly move down." When asked about any accidents that may have happened E8 indicated there were none with R14 and the only thing that happened with R14 was the back would recline slowly.

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F9999	Continued From page 22 Interview with E8 on 5-31-07 at 9:25am stated "when (the geriatric chair) failed with (R14), and transferred (R14) back to bed, and the other CNA would take the chair to the end of the hall and would get another chair the next day. When E8 was asked if she reported the malfunction of R14's chair to Maintenance, E8 replied, "No, I stayed with (R14), the other aides would take the chair to the end of the hall and would get another chair the next day." I thought the other CNA was reporting it. . . and not sure if it got reported . . . could not remember who the other CNA was ." E7, CNA stated on 5-29-07 at 1:10pm "about the (geriatric chair) non-functioning - yeah the hydraulics nonfunctioning . Whenever we put (R14) in it, it would ease up all by itself. I think they fixed it. (R14) didn't have the strength in her legs - she would just lay there." When asked how she knew the chair was not working, E7 stated "(R14) was more gradually coming more upright." E7 stated the facility had two of these blue chairs but couldn't remember who had the other blue chair. E7 said she knew that this blue geriatric chair was taken to Maintenance to be fixed. On 5-29-07 at 10:15am Z1, COTA identified the geriatric chair used by R3 on 5-7-07 at the time of the fall. The geriatric chair has a locking lever located on the back of the chair which is used to lock the chair in a reclined position, Z1 positioned the lever to lock the chair in a reclined position. With the lever in a locked position the chair was put in the upright position by applying slight pressure on the footrest. E6, Maintenance Director was interviewed about	F9999		

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the reclining geriatric chair on 5-29-07 at 11:55am. E6 stated "(E6) had checked the chair (after R3 had fallen)." E6 locked the brake with the chair in the reclined position and demonstrated how he had checked the chair by pushing up on the back and the chair appeared to be okay. The surveyor was then able with light pressure using only one hand pushed on the foot rest and put the chair in an upright position. E6 stated "I guess I didn't check it that way." When E6 tried to set the brake on (the geriatric chair) again, E6 stated "I lost the brakes entirely." E6 then dissembled the brake mechanism to try and repair the part. E6 said he would have to get the book out to see how it goes back together. When asked if this was the same chair that was used for R14, E6 replied, "Yeah, this is (R14's) chair." When asked how would you know that information, E6 indicated the hangtag at the lower back of the chair with R14's last name written on the tag in black marker. E6 stated each resident's chair is marked the same way.

During continued interview with E6 about the geriatric chair at 12:45pm, E6 did not recall any work order on the blue geriatric chair. Staff would complete a work order to tell him if the geriatric chair needed repair. E6 later stated he looked at the Maintenance Tickets back to November of 2005 and there is not one for that chair. A review of the tickets confirms the interview. The only Maintenance log was for May of 2007 and that was conducted after R3's fall on 5-7-07.

On 5-30-07 at 10:55am E6 was asked about a Preventative Maintenance Plan to check for problems with equipment. E6 stated this is a new policy they have started for him to start using and

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F9999	Continued From page 24 verified none have been done as of the time at this interview. E6 referenced the May 2007 log stating the facility was implementing a Preventative Maintenance Plan that would include geriatric chairs. Z3, Technical Support Representative from the manufacturer of the geriatric chair was interviewed on 5-31-07 at 9:15am. Z3 was asked to explain how the brake functioned that supported the back when it was in the reclined position. Z3 stated "the brake itself - the lever itself is the brake not the weight of the person. Whether somebody is (seated) in there or not it will still lock." Z3 continued "It's a mechanical lock." The surveyor described how the chair had released the foot rest and the back came up to an upright position when pushed gently with hand pressure after the brake was set by E6. Z3 replied, "It needs to be replaced." When asked if Z3 meant the brake, Z3 stated "Yes, it needs to be replaced, it's going to wear out, that's why it's not holding." The surveyor described that CNA staff stated they had problems with the chair not holding and took it to Maintenance, then two weeks later it failed again and it would have to go back to Maintenance. Z3 replied, "But if the brake is not sticking it should probably be replaced." (A)	F9999		