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	145911	A. BUILDING _____ B. WING _____	C 08/22/2007

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F 333	Continued From page 9 E22 gave Ativan cream one time only. Documented on this report is, "No adverse reaction were observed from this error of medication use. Medication Error Report for R2 dated 9/27/06 documents Z7 gave R2 Ativan 0.5mg. one time on 9/27/06 without a physicians order. Interview with E22 on 8/20/07 at 9:45 a.m. stated R2 "would not take Ativan by mouth so I borrowed from another resident a cream and gave transdermally." Interview with Z9, (Pharmacist) on 8/20/07 at 9:25 a.m. stated "Ativan can be given in a compounded gel, but we don't do it because it is so complicated for us to do." The Clinical Record for R2 shows his medications are obtained from the pharmacy where Z9 is employed. Interview with Z5, Physician, on 8/15/07 at 11:00 a.m. stated he did not consider R2 had an allergy to Ativan. Z5 stated "it is not an allergy, it is just an adverse effect."	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.680a) 300.1210a) 300.1210b)6) 300.3240a)b)c) Section 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm	F9999		

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F9999	Continued From page 10 restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel. 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. Restorative measures shall include at a minimum the following procedures: Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 11 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) These regulations were not met as evidenced by: Based on observation, record review and interview, the facility failed to accurately assess bed mobility and failed to report R3's movement to the edge of the bed with knees off the mattress numerous times for 1 of 5 sampled residents (R3) who use side rails and require assist for bed mobility. This resulted in R3 being found unresponsive with her head partially entrapped between the upper side rail and mattress, her body off the bed, and her knees on the floor. This resulted in R3's death.	F9999		

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F9999	Continued From page 12 Findings include: Physician Order Sheet (PO) dated 8/07 lists R3 was admitted on 1/1/ 2007 with diagnoses to include Dementia. Also listed on this PO sheet is: up as tolerated in wheel chair and may have upper side rails. The Minimum Data Set (MDS) Significant Change Assessment dated 7/31/2007 lists R3 had long and short term memory problems and was moderately impaired for decision making, did not ambulate, and required total assistance for bed mobility and transfers. This MDS also listed R3's height as 61 inches and weight as 124 pounds. Care Plan dated 8/2/07 lists R3 could no longer walk and, "I need you to place my hand on the side rails to attempt to help you with turning and repositioning." The Fall Assessment dated 7/31/07 lists R3 as moderate risk for falls with no previous falls. R3's total body and functional assessment dated 7/07 lists R3 is totally dependent on staff for all Activities of Daily Living, however mobility assist status had not been addressed on this assessment. Listed on this form for needs to be addressed is R3 is non-ambulatory, sit to stand lift for all transfers, and staff moves R3 around facility by wheel chair. Assessment For Use Of Side Rails dated 7/31/07 lists R3 transferred with a sit to stand lift, non ambulatory, turn and reposition by staff and use of bilateral half upper rails. The Physical Therapy Assessment dated 1/9/07 through 6/20/07 lists R3 as non-ambulatory, maximum for bed mobility and is at risk for falls. Discharge Occupational note dated 6/21/07 lists R3 needed maximum	F9999		

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F9999	Continued From page 13 assist for bed mobility. According to the facility Occurrence Report of 8/2/07, R3 was found on 8/2/07 at 7:05 a.m. on her knees beside her bed with her head leaning to the right against the top 1/2 side rail. Cardiopulmonary Resuscitation was initiated until Z3, Physician, said to discontinue as R3 was a Do Not Resuscitate. R3 was pronounced dead approximately 7:23 a.m. An autopsy was requested by Z1, Coroner, and the cause of death was determined to be "positional asphyxiation" Continued on this facility report was..."it is our conclusion that with the head of the bed slightly elevated, an air mattress in place along with a turn sheet; (R3) had to have been moving about in the bed, slid off the side of the bed, resulting in the position (R3) was found in." In Nurses Notes dated 8/02/07 at 7:07 a.m. E6 (LPN), Licensed Practical Nurse, stated, "(R3) found with head between mattress and upper L (left) bed rail, face down and turned to (R3's) right slightly with rest of (R3's) body off mattress in a fetal position with extremities blue/purple in color." "(R3's) head removed from between mattress and bed rail." Nurses notes dated 8/02/07 at 7:10 a.m. by E10 (LPN), stated, "upon entering room (R3) was observed on knees at side of bed with head bent forward R (right) ear was bent in side rail. L (left) side of appeared cyanotic, arms dangling and et (and) cyanotic." Interview with E17, Maintenance Director, on 8/14/07 at 1:10 p.m. stated he checks all equipment that is brought in by families to be used in the facility. E17 stated he followed the directions for inflating R3's air mattress and made it pretty firm.	F9999		

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F9999	Continued From page 14 Interview with E9 (CNA), Certified Nurse Aide, on 8/13/07 at 1:10 p.m. confirmed information in her written statement. E9 stated she found R3 around 7:00 a.m. "with her feet on the floor because (R3) was on her knees. I noticed (R3's) head between the rail and bed. The rail was up with (R3's) head pushed down between the mattress and bed rail. (R3's) face wasn't down it was like (R3's) head was facing up toward the ceiling. The head of the bed was just barely tilted. All of the side of (R3's) face was in the rail but not through it to the neck. (R3's) neck was beside the rail." E9 stated R3 would not move unless helped, but could transfer with a sit to stand lift and could put her feet on the lift to transfer. Interview with E6 (LPN) on 8/9/07 at 2:15 p.m. confirmed information in her written statement. E6 stated this is the way I found R3. E6 stated "my first thought was to get (R3's) head out between the mattress and rail...the head was pointed out and downward to the right...(R3's) ear was underneath the upper rail to the outside. (E6) stated she had to mash (R3's) ear to get her head out. (E6) stated (R3's) arms were hanging on the ground...hands were touching the floor and the knees were on the floor...blue pressure areas was on (R3's) knees." Interview with E13 (CNA) on 8/13/07 at 1:45 p.m. confirmed information in his written statement. E13 stated he had repositioned R3 at 4:00 a.m. E13 stated, "(R3's) torso was in the middle of the mattress, (R3's) knees were close to the edge of the mattress but not over...(R3) would roll over the towel or blanket to get to her back...(R3) could move a little."	F9999		

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F9999	Continued From page 15 Interview with E5 on 8/13/07 at 10:45 a.m. stated on two occasions in the morning, she had seen R3 on her left side facing the room and R3's knees and feet would be partially off the mattress. E5 stated, "If I had not moved (R3) she would have slid out of bed." E5 stated she did report this 4 or 5 weeks ago to a nurse but did not recall who that nurse was. Interview with E7 on 8/9/07 at 2:40 p.m. stated R3 would become agitated by moaning and jerking her arms when turned on her left side facing the rail and room. E7 stated, "I have seen, when checking on (R3) after positioning her, (R3) had scooted to the edge of the bed and I would have to move (R3) back to the middle of the bed." E7 stated, "Numerous times I found (R3) like that." When E7 was asked if she reported this to the nurse, E7 stated, "No I didn't." Interview with E12 (LPN) on 8/13/07 at 12:35 p.m. confirmed information in her written statement. E12 stated she had seen R3 in bed with her head up 20 to 30 degrees between 5:45 a.m. and 6:00 a.m. E12 stated she could not be certain if R3 was close to the edge of the bed or not. Interview with E3 (LPN), Assessment Coordinator, on 8/9/07 at 3:00 p.m.stated R3 had been assessed for bed mobility, had 1/2 side rails, needed one assist to turn in bed. E3 stated, "(R3) used the side rail (staff) had to place (R3's) hand on the side rail to help turn...would lean to the side while in the wheel chair and no one put (R3) this way." Interview with E3 on 8/15/07 at 9:00 a.m. stated, "no one reported to me (R3) could and did put her knees over the edge of the	F9999		

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F9999	Continued From page 16 bed." Interview with Z3, Physician, on 8/14/07 at 1:55 p.m., stated he seldom saw R3, that Z2 (NP) Nurse Practitioner, did. Interview with Z2 (NP) on 8/16/07 at 10:20 a.m. stated she had not physically moved R3 or had R3 move for her and would not know if R3 could turn herself. Interview with Z1, Coroner, on 8/13/07 at 8:45 a.m., stated from the pictures he had taken, R3 could not have gotten her head between the rails. Z1 stated it would have taken but a few seconds to shut off the Carotid Artery with the position R3 was in. Z1 stated according to R3's rigidity R3 did die between 5:30 a.m. and 7:00 a.m. Z1 stated according to his estimate from the information he had received from staff, "I believe (R3's) face was down in the mattress enough and her position to cause position asphyxiation" Observation on 8/9/07 at 2:10 p.m. with E1 (Administrator), E2 (DON), Director of Nursing, and E14 (Field Nurse Supervisor) R3's bed was observed. The bed was up against the wall with 1/2 rail down and the other side of the bed was to the room with a 1/2 side rail. The mattress fit top and bottom with no gaps. The mattress had a two inch gap from the edge of the mattress to the side rail. The air mattress also had a two inch gap from the edge of the air mattress to the edge of the side rail. The mattress width covered from the bottom of the side rail to approximately 1-2 inches to the first division bar of the side rail. The 1/2 side rail had a division bar of a four inch space at the top of the rail and a five inch space at the bottom of the rail. The side rail fit firmly	F9999		

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F9999	Continued From page 17 and properly. From the mattress top to the floor measured 17 1/2 inches. The air mattress did redistribute air when pushed on by hand but not enough to interfere with unsafe positioning. According to the Preliminary Autopsy Report dated 8/4/07 the cause of R3's death was, "Positional Asphyxia, Compression of the neck, and Entrapment of neck b/w (between) bed and railing." (A)	F9999		