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	145489	A. BUILDING _____ B. WING _____	C 07/15/2008

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F 442	Continued From page 13 11:45am, and E7, Licensed Practical Nurse on 7/8/08 at approximately 11:15am found that no Isolation Precautions had been taken while R4 was still at the facility. From 6/25/08 when the diarrhea started until 6/29/08, R4 shared a bathroom with another resident.	F 442		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a 300.1210b)6) 300.2210a) 300.2210b)5) 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: b)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 300.2210 Maintenance	F9999		

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F9999	Continued From page 14 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. These requirements were not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all resident beds were checked on a routine basis to make sure they were properly maintained. R4 fell over an unprotected bed rail post that caused a deep laceration, and the bed post became impaled into R4's upper right thigh. R4 required surgery to cleanse and close the deep tissue injury. R4 required two subsequent hospitalizations for wound infection and for Clostridium Difficile Toxin/Dehydration secondary to the deep tissue injury. The facility was aware that these kind of protective knobs could easily come off the top of the bedrail post, but failed to check other resident beds with the same kind of bed post on a regular scheduled routine to prevent an injury from occurring. The facility had a total of 57 beds, and out of those 57 there were 50 that still had the similar brackets. Findings include: R4's most current Physician's Order Sheet (POS) dated June 2008 has diagnoses listed as Cardiomyopathy, Emboli Strokes, Supraventricular Tachycardia, Chronic Obstructive Pulmonary Disease, Anxiety, and Dementia with Behaviors. R4's fall assessment	F9999		

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F9999	Continued From page 15 dated 4/14/08 has R4 assessed to be at moderate fall risk. The Minimum Data Set (MDS) dated 5/14/08 has R4 as independent in ambulation and transfer, but required limited assistance with her Activities of Daily Living. This MDS also showed that R4's Range of Motion had no limitations. R4's cognitive status at this time of assessment showed that R4 was moderately impaired - decisions poor, cues/supervision required. Review of the incident reports for May 2008 found that R4 had a fall on 5/13/08 at 5:45am. R4 was found on the floor beside her bed. R4 sustained a small scratch on the left side of her chin. According to E7, Licensed Practical Nurse (LPN) on 7/7/08 at approximately 1:30pm, no preventative measures were put in place after this fall. Incident Report dated 5/22/08 at 8:50am showed that R4 was found in her room by E3, Certified Nurse Aide (CNA). Interview with E3 on 7/7/08 at 11:45am found that E3 walked into R4's room and saw that R4 had fallen over the siderail post on the end of the bed. E3 stated that she knew right away that it was serious and ran to get a nurse for help. E3 stated that she and E9, Director of Nursing, had to "lift" R4 off of the bed bracket. E3 said that R4 was wearing slacks at the time of this incident. E3 said that E9 had another nurse call 911 immediately and R4's vital signs were done, as well as checking her oxygen level which was documented as 82%. Nursing Notes dated 5/22/08 showed that the ambulance arrived at 8:59am and took R4 to the hospital Emergency Room immediately. It is also documented at that time that there was minor	F9999		

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F9999	Continued From page 16 bleeding and that R4 was responsive. The Hospital Emergency Room (ER) Notes dated 5/22/08 documents, "The patient fell while in the nursing home and impaled a metal bed post on her right thigh. The patient was found with the metal rod stuck in her thigh." Further ER documentation by Z1, ER Physician, "All the visible structures, which included nerves and tendons appeared to be intact and there was no active bleeding in spite of the fact that the patient is taking Coumadin." Z1 was interviewed on 7/8/08 at approximately 10:30am regarding the wound sustained by R4. Z1 stated that R4 was, "very lucky in that she could have hit the femoral artery and would not have survived." Interview on 7/8/08 at approximately 2:30pm with E4, Maintenance Supervisor found that on the day of the incident R4's bed had the siderail post on her bed but there was no side rail. The Emergency Room Report dated 5/22/08 has an assessment of the area describing the right groin injury as, "Full thickness 6 and 1/2 inch laceration that was deeper in the center of the laceration able to visualize deeper right inguinal structures. Fascia, muscle, nerves able to be visualized but no active bleeding." The wound was checked for any foreign particles, cleaned, and surgically repaired. The Physician at the hospital gave Ancef 2gm intravenously (IV) to prevent an infection. Nursing Notes dated 5/22/08 at 4:45pm note that R4 returned to the facility, admitted back into a low bed, and had a urinary catheter. It is noted at the time R4 returned, there were 15 staples in place at the wound area. Review of the	F9999		

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F9999	Continued From page 17 discharge medications found that Z1, Physician had put R4 on Vicodin 5/500 for pain. R4 also returned to the facility with an order for Levaquin 250 milligrams (mg) daily for 7 days, as another antibiotic to prevent any infection. Nursing Notes of 5/29/08 note that R4 had gone to see Z3, Wound Specialist. When R4 returned to the facility Z3 had given orders for an antibiotic ointment to be applied to the thigh incision and it notes that the incision looked red and had clear drainage. Nursing Notes on 5/30/08 at 7:30am note that the incision was red and puffy in areas. Nursing staff continue to document that the wound was red and puffy until 5/31/08 at 11:20am when documentation notes that the wound was scabbing, well approximated, had greenish scabbing, and red around the scab and was warm to the touch. Z3 was called and an order to start Bactrim DS twice a day for 7 days was given. At this time the resident was showing signs of pain by moaning and facial grimacing as noted in the notes. . Nursing Notes dated 6/01/08 during the night shift document that a Certified Nursing Assistant brought to the nurse's attention that the wound displayed redness, heat, and drainage with an odor. Continued nursing charting documents that the right groin area was opening with foul smelling drainage. The facility called Z3, Wound Specialist and Z3 gave orders to transfer R4 to the hospital. The facility was called and was told that R4 was admitted to the hospital for treatment. The Consultation notes dated 6/01/08 from the hospital documents, "the hospital did a wound culture and started (R4) on Vancomycin and continue the Levaquin for gram negative coverage in hopes to avoid aminoglycoside at	F9999		

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F9999	Continued From page 18 this point." The Emergency Room Report on 6/01/08 states, "The patient has not been ambulatory for the last 10 days since her traumatic right inguinal wound on the bed edge at the nursing home." It also documents that, "the wound bed was approximately 6 inches with yellowish green base and black edges. No active separation, foul odor." R4 was started on Levaquin 500 milligrams IV plus Nafcillin IV 1 gram every 4 hours. A Tetanus Shot was also given. The Emergency Room Report documents that R4 was admitted for continued treatment. The admission transfer sheet dated 6/13/08 showed that R4 returned to the facility and was to continue the IV Vancomycin. A significant change Minimum Data Set (MDS) was done on 6/20/08, which showed that R4 had declined. R4 was nonambulatory, and required extensive assistance with all Activities of Daily Living. R4 was incontinent of bowel and had an indwelling urinary catheter. This MDS also showed that R4 had a Stage I pressure area on the coccyx and required a chair to prevent rising for her safety. Documentation on the Nursing Notes dated 6/24/08 found that R4 had developed an open pressure sore on the coccyx. Nursing Notes dated 6/29/08 show R4 required hospitalization for Clostridium Difficile(C-Diff) and Dehydration. On 7/7/08 at 4:15pm Z2 stated that the Clostridium Difficile (C-Diff) was a result of the potent antibiotics required to treat the thigh wound infection. On 7/8/08 at approximately 2:30pm the siderail assembly bracket which was on R4's bed on	F9999		

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F9999	Continued From page 19 5/22/08 was observed. A steel post bracket approximately 18 to 20 inches high is attached to the bed frame at each corner of the bed. The side rail itself is secured to this bracket. This bracket is equipped with a hard plastic protective cap which sits on top of this post bracket, with a portion of the cap resting inside the hollow post. When the protective cap is removed, there are two sharp edges on the steel post that are exposed. During this observation the sharp edges that were exposed when the protective cap was taken off, felt like a sharp knife like point. Interview with E3 on 7/8/08 at approximately 3:00pm found that either on the same day of the incident or the week before the incident, she had torn her uniform on another similar post that was missing the protective knob. Interview with E4, Maintenance Director, on 7/7/08 at approximately 2:30pm and on 7/8/08 at approximately 11:00am found that the facility had many beds with these types of brackets on them and prior to the incident some of the protective knobs were known to come off easily, either with getting tangled up in bed linens or confused residents removing them by hand. E4 stated that as soon as he was made aware of this he would get them back on and crimp the bracket with a pair of pliers so the knobs could not come off again. E4 said on 7/8/08 during the interview that staff checked all beds monthly for missing protective caps, but did not check that caps were secure. E4 provided documentation from a bed audit conducted on 5/22/08, showing the facility had a total of 57 beds and out of those 57 beds, 50 still had the similar brackets that R4 had on her bed.	F9999		

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F9999	Continued From page 20 (A)	F9999		