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F 000	INITIAL COMMENTS Complaint #1220615/IL56521 F309 & F253 Complaint #1220626/IL56542 F309, F323 & F221	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a medical need for the use of side rails and failed to accurately assess and provide a reduction plan for the use of side rails for five of six residents reviewed with side rails, R1, R3, R4, R5 and R6 in a sample of six. Findings include: Facility's undated Side Rail Protocol states "Side rails on a bed are primarily meant to promote resident bed mobility. They can be appropriately used for safety when turning a resident or as a transfer/positioning aide. Any side rail (full rail) that prevents a resident from getting out of bed is a restraint. The following examples (1, 2 and 3) are side rails that are not a restraint. 1) Two bilateral side rails are to be three quarter or half on each side. 2) One side of bed against the wall may have a three quarter or half rail on the open side. 3) One full, three quarter or half rail may be	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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used on one side of a bed while the other side of the bed is fully open, i.e. not up against the wall." "An initial side rail assessment is completed and placed in the chart. Quarterly reassessments are completed to evaluate the current need for the use of side rails."

On 3-27-12 at 3:15 pm, E2 (DON/Director of Nursing) stated the following: When a resident is admitted, the admitting nurse completes a side rail assessment and then the restorative nurse completes a reassessment quarterly or more often if needed.

1. Facility's Accident/Incident Investigation dated 2-3-12 states R3 was noted on the floor next to bed. R3 climbed out of bed and fell onto floor. R3 sustained a hematoma to the left side of her forehead with a left wrist injury and left swollen hip. Nursing note dated 2-3-12 and 6:00 pm states R3 was admitted to the hospital with a fracture to the left femur and left wrist.

R3's POS (Physician's Order Sheet) dated 1-16-12 states "may have 1/2 siderails x's 2 to aid with turning and positioning." R3's side rail assessment form dated 5-28-11 and last updated 1-16-12 states R3 is to have two half rails. At the top of this form is this statement "The use of bed rails as a restraint is prohibited unless they are necessary to treat a resident's medical symptom. If the bed rails are used for resident safety it is not considered a restraint." Items checked on R3's assessment were "alteration in safety awareness due to cognitive decline and history of falls." There is no documentation of how R3's side rails were being used to treat a medical condition or enabling R3.

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F 221	Continued From page 2 On 3-27-12 at 10:30 am, E5 (Social Service) stated on 2-3-12 she heard an alarm sounding and went to R3's room finding R3 on the floor next to her bed. E5 stated R3's side rail was up on the side of the bed where R3 had fallen. E5 said "it looks like (R3) climbed over the side rail." E5 indicated R3's bed had either 3/4 or full side rails at that time. On 3-27-12 at 11:35 am, E4 (Housekeeping Supervisor) stated the following: When R3 returned from a hospital stay on 2-1-12, R3 was moved to another room due to being in isolation. E4 did not move R3's bed to the new room but used the bed already in the room. The new bed in the new room had full side rails on the bed. E4 thought the long rails would be better and R3 would be safer with the full rails. On 3-27-12 at 11:15 am, E16 (Maintenance Supervisor) stated R3 had 3/4 side rails on the bed in the room used before 2-2-12 and full side rails were on the bed R3 was in when she fell on 2-3-12. On 3-27-12 at 11:00 am, E2 stated she was working on 2-3-12 when R3 sustained a fall resulting in a left femur and wrist fracture. E2 stated R3 went over the side rail and landed on the floor. E2 stated both of R3's side rails were up at that time. E2 confirmed that R3 had the incorrect side rails (full) applied to her bed. 2. On 3-27-12 at 1:35 pm, R4 was in bed with two full side rails up on the bed. R4's care plan dated 12-27-12 states "full side rails x 2 per family request for safety and to assist with self mobility."	F 221		

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This care plan also states R4 needs assistance to roll in bed.

R4's side rail assessment dated 2-15-12 states the facility is recommending two full rails indicated to serve as an enabler and promote mobility. Comments at the bottom of the page is typed "Per POA (Power of Attorney) request (2) 3/4th length rails." The side rail assessment does not indicate how the full side rails are being used to treat any medical condition or how they are enabling R4. The comment section states family requested 3/4 side rails and R4 is using full rails. There is no documentation of a restraint reduction plan in R4's record.

On 3-27-12 at 3:15 pm, E2 stated she has recommended other interventions to R4's family including shorter side rails. E2 states R4's family wants R4 to have full side rails.

3. On 3-27-12 at 2:00 pm, R5 was in bed with two 1/2 side rails up on the bed. At 2:15 pm that same day, E17 (CNA/Certified Nursing Assistant) stated R5 cannot use the side rails to help with turning and positioning needing staff to do it for her. R5's side rail assessment dated 4-13-11 and last updated 12-28-11 states R5 is to have two half side rails to serve as an enabler and promote mobility.

On 3-27-12 at 3:15 pm, R2 confirmed that R5 would not need the 1/2 side rails since she cannot use them to help with turning and positioning.

4. On 3-27-12 at 2:00 pm, R6's bed was empty but had two unpadded 1/2 side rails up on the

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F 221	Continued From page 4 bed. R6's side rail assessment dated 7-7-11 and last updated 12-26-11 has an x in two recommendations; 1)side rails are indicated to serve as an enabler and promote mobility and 2) side rails do not eppear to be indicated at this time. The side rail assessment shows R6 does not need the side rails for support or positioning but needs them for decrease in cognitive ability, history of falls, poort balance/trunk control, and medication requiring safety precautions. The assessment mentions a diagnosis of seizures but does not state to pad the side rails. 5. R1's side rail assessment dated 11-4-11 and last updated 1-25-12 states R1 needs two half side rails for safety and to serve as an enabler and promote mobility. his assessment states R1 is nonambulatory, uses side rails for support or positioning and has medication which required safety precautions. This assessment does not show what medical condition is being aided by use of side rails, any other interventions attempted or any reduction plan.	F 221		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain two of two rooms belonging to one of six residents (R1) reviewed in a sample of	F 253		

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F 253	Continued From page 5 six and one resident (R7) on the supplemental sample. Findings include: On 2-10-12 at 9:40 am, R7's room and R1's room had nightstands and/or dresser drawers that were stained, dirty or had peeling finishes. On 2-10-12 at 12:40 pm, Z1, family of R1 stated when they were cleaning out R1's room, they found items that were dirty and the drawers looked moldy and dirty. Z1 stated there was also broken glass in the nightstand drawer. On 2-10-12 at 2:30 pm, E1 (Administrator) stated yes some of the drawers were worn and stained and that they would put drawer liners in all of the drawers in the facility. On 2-10-12 at 9:50 am, E18 (Housekeeper) stated when residents are discharged and all their items removed from their room, housekeeping deep cleans everything in the room. E18 stated all the above rooms had already been cleaned.	F 253		
F 309 SS=D	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	F 309		

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by:
Based on interview and record review, the facility failed to immediately initiate CPR(Cardiopulmonary Resucitation) for one of six residents (R2) reviewed in a sample of six. R2 became unresponsive during a mechanical lift transfer and expired. The facility failed to assess one of six residents (R1) reviewed in a sample of six for decline in condition. R1 was admitted to the hospital with severe lower leg cellulitis.

Findings include:

1. R2's nursing notes dated 2-5-12 state the following: 3:35 pm-R2 transfer to wheelchair by mechanical lift and two CNAs (Certified Nursing Assistants). 3:40 pm R2 "unresponsive, color purple, no pulse, full code. 911 called per nurse transfer to bed per staff CPR start per staff.." Notes go on the say paramedics arrived and R2 expired at 4:00 pm.

On 3-2-12 at 10:30 am, E13 (CNA) stated the following: On 2-5-12, E13 and E11 (CNA) used the mechanical lift to transfer R2 from bed to chair. When R2 was almost settled in the chair, E11 said that R2 did not look right then, that he was "coding" and for E13 to go get the nurse. E13 went the the nurses desk and told E14 (LPN/Licensed Practical Nurse) who was on the phone, "(R2's) dying." E13 stated E14 waved her off so she went back to R2's room. E13 stated E11 started yelling for the nurse and trying to do chest compressions while R2 was in the wheelchair. E13 stated they called for the nurse at least six times before E14 came to the room. E13 was sent by E14 to get a nurse down another hallway. When E13 returned R2 was put back in

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bed with the mechanical lift and CPR started by E9 (CNA). E13 stated CNAs can initiate CPR without a nurse present unless told not too.

On 3-1-12 at 3:00 pm, E11 stated the following: On 2-5-12, E11 was assisting E13 transferring R2 by mechanical lift from bed to wheelchair when R2 stated he could not breathe. E11 said R2 was gasping and turning purple/blue. E11 and E13 lowered R2 the rest of the way to the wheelchair and E11 sent E13 to get the nurse. E13 came back without the nurse stating E14 was on the phone and waved her away. E11 yelled for the nurse many times before she left R2's room and went and "grabbed" E14 and brought her to R2's room. E11 stated E14 slapped R2 to try and arouse him and rubbed R2's chest. E14 then asked staff to get the other nurse on duty (E15). E15 instructed E11 to get the crash cart from B wing. E11 stated there was no oxygen or Ambu bag on the crash cart so another staff ran and got the crash cart from A wing. "No one knew what to do." E11 stated she was instructed not to do CPR by E14 who started to do a chest rub on R2. E15 then instructed them to place R2 in bed and a CNA started CPR. E11 stated it was about five or six minutes from the time R2 started coding until E14 and other staff arrived. E11 stated she has had CPR training in the last four months.

E6 (CNA) was interviewed 3-2-12 at 9:40 am stating he heard an all page on the date of the incident, went to R2's room and assisted with the CPR. E6 was unsure how long it took for CPR to be initiated. E6 did state it took 1-2 minutes to get R2 transferred back into bed to start the CPR. E6 stated there was enough staff they could have just lifted him to the floor and started CPR then.

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R2's POS (Physician's Order Sheet) dated 1-16-12 to 2-15-12 states R2 is a full code. R2's Do Not Resuscitate (DNR) form dated 12-20-10 shows R2 is to be a full code.

Facility's Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) revised 2006 states "Cardiac arrest is defined as inadequate cardiac contractions resulting in insufficient blood flow throughout the body (pulselessness). Sudden cardiac arrest (SCA) is a leading cause of death in adults. Depending on the underlying cause, the chances of surviving SCA may be increased if CPR is initiated immediately upon collapse." "If an individual is found unresponsive and without a pulse, a licensed staff person who is certified in CPR/BLS shall initiate CPR..."

On 11-2-11, E6, E9 and E12 (CNAs) obtained certificates for passing adult CPR certification.

On 3-1-12 at 12:45 pm, E2 stated after the investigation she had concerns with the length of time before CPR was initiated. E2 stated staff should have immediately slid R2 to the ground and initiated CPR. E2 stated E14 was not organized and did not take charge of the situation. E14 was terminated.

2. R1's POS for 1-12 shows R1 has diagnoses of peripheral vascular disease, dementia, congestive heart failure, diabetes mellitus and osteomyelitis. This POS contains an order to apply Mycolog cream two times a day to R1's left leg. R1's order dated 11-29-11 states to refer R1 to vascular surgery for PAD (Peripheral Artery Disease) and increased lower extremity pain.

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Nursing notes from 1-1-12 to 1-7-12 contain no documentation of any problems/changes to R1's left lower leg. Nursing notes dated 1-4-12 at 3:30 pm show R1 was slurring his words and had a temperature of 102 degrees for which Tylenol was given. Nursing notes untimed and dated 1-5-12 stated R5 had an emesis for which R1's physician was notified. Another untimed note on 1-5-12 states R1 complained of his legs hurting and was again given Tylenol. On 1-6-12, nursing notes state R1 was again given pain medication. Nursing notes dated 1-7-12 at 3:00 am document R1 was given pain medication and catheterized for a urine specimen. There is no documentation at this time of any assessment, problems/changes with R1 left leg. Nursing notes dated 1-7-12 at 6:15 pm state R1 was sweating, pale and lethargic. R1's physician was called and R1 was sent to the hospital.

R1's TAR (Treatment Administration Record) for 12-16-11 through 1-15-12 shows the Mycolog cream administered two times a day to R1's left leg. There is no accompanying assessment of this leg or documentation on the form of any problems with R1's left leg.

Hospital Emergency Department notes dated 1-7-12 state "Patient presents per EMS (Emergency Medical System) for evaluation of altered mental status...Typically wheelchair or bed bound but conversive and not confused. Family unsure when symptoms initially began...only complaint is left leg pain...Erythema noted to LLE (left lower extremity) no warmth. Serous drainage anterior left leg...left leg tender...Only focal finding on exam is tachypnea and LLE

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F 309	Continued From page 10 erythema. Plan to treat as cellulitis..." The note continues patient has some increased left lower leg swelling that has started over the past couple days. Patient has 4 plus pitting edema in lower legs. Disoriented to time and situation. Hospital attending physician assessment dated 1-7-12 states "(R1) is a ...with IDDM (Insulin Dependent Diabetes Mellitus), peripheral neuropathy, Charcot Left foot... admitted with severe LLE cellulitis and delirium." Per this assessment, R1 was treated with intravenous antibiotics for the cellulitis. On 3-27-12 at 3:15 pm, E2 verified nursing staff missed the change in R1's left leg. E2 stated nursing staff involved were disciplined/let go for not properly assessing R1.	F 309		
F 323 SS=G	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: Based on interview and record review, the facility failed to ensure one of six residents (R3) reviewed with falls in a sample of six had the correct side rails on their bed per their plan of care. This failure resulted in R3 climbing over full side rails and fell sustaining a left femur and wrist	F 323		

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fracture.

Findings include:

R3's nursing notes dated 2-3-12 at 3:15 pm state "Summoned to res (resident) room resident lying on the floor next to bed on her Lt. (left) side moderate amt (amount) of blood on floor. Res had been incontinent of BM (bowel movement) tried to climb out of bed towards bathroom and fell. Large hematoma Lt. side forehead and wrist injury complains of right shoulder pain and left hip pain which was noted to be swollen..." Nursing note dated 2-3-12 at 6:00 pm states R3 was admitted to the hospital with a fracture to the left femur and left wrist. Facility's Accident/Incident Investigation dated 2-3-12 states "Resident was noted on the floor next to bed. BM in bed, alarm going off...Resident climbed out of bed and fell onto floor. Hematoma left side forehead left wrist injury left swollen hip."

R3's POS (Physician's Order Sheet) dated 1-16-12 states "may have 1/2 siderails x's 2 to aid with turning and positioning." R3's side rail assessment form dated 5-28-11 and last updated 1-16-12 states R3 is to have two half rails. At the top of this form is this statement "The use of bed rails as a restraint is prohibited unless they are necessary to treat a resident's medical symptom. If the bed rails are used for resident safety it is not considered a restraint." Items checked on R3's assessment were "alteration in safety awareness due to cognitive decline and history of falls." There is no documentation of how R3's side rails were being used to treat a medical condition or enabling R3.

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On 3-27-12 at 10:30 am, E5 (Social Service) stated on 2-3-12 she heard an alarm sounding and went to R3's room finding R3 on the floor next to her bed. E5 stated R3's side rail was up on the side of the bed where R3 had fallen. E5 said "it looks like (R3) climbed over the side rail." E5 indicated R3's bed had either 3/4 or full side rails at that time.

On 3-27-12 at 11:35 am, E4 (Housekeeping Supervisor) stated the following: When R3 returned from a hospital stay on 2-1-12, R3 was moved to another room due to being in isolation. E4 did not move R3's bed to the new room but used the bed already in the room. The new bed in the new room had full side rails on the bed. E4 thought the long rails would be better and R3 would be safer with the full rails.

On 3-27-12 at 11:15 am, E16 (Maintenance Supervisor) stated R3 had 3/4 side rails on the bed in the room used before 2-2-12 and full side rails were on the bed R3 was in when she fell on 2-3-12.

On 3-27-12 at 11:00 am, E2 stated she was working on 2-3-12 when R3 sustained a fall resulting in a left femur and wrist fracture. E2 stated R3 went over the side rail and landed on the floor. E2 stated both of R3's side rails were up at that time. E2 confirmed R3 had full side rails on her bed instead of half rails, climbed over the rails falling and sustaining a left femur and wrist fracture.