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F 000	INITIAL COMMENTS	F 000		
F 221 SS=E	Annual Licensure and Certification Survey. 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 observations, record reviews and interview, the facility failed to assess and implement less restrictive measures attempted prior to utilizing side rails for four of eight residents (R7, R9, R37, R81) reviewed for physical restraints inside the sample of 15 residents, and five residents (R11, R67, R84, R87 and R92) in the supplemental sample. Findings include: During the facility survey from 9/9/14 through 9/11/14 R7, R9, and R37 were noted with two full side rails up when in bed. 1) R7's Physician's Order Sheet (POS) dated September 2014 indicates: Low air loss mattress with side rails x2. R7's Assistive Device/ Restraint Assessments dated 8/21/14 indicates: two full side rails up with seizure pads and fall prevention related to use of low air loss mattress (per manufacturer's recommendation). This device restricts R7's freedom of movement and/or access to own	F 221		

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

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F 221	Continued From page 1 body, with risk of injury and entrapment. 2) R9's POS dated September 2014 indicates: Low air loss mattress with side rails x2. R9's Assistive Device/Restraint Assessments dated 8/2/14 indicate; two full side rails and fall prevention related to use of low air loss mattress (per manufacturer's recommendation). This device restricts R9's freedom of movement and/or access to own body. 3) R37's POS dated September 2014 indicates; Upper side rails x2 per manufacturer's recommendation with low air loss mattress. On 9/11/14 at 9:45 AM, R7 was resting in bed with two full side rails up. R37's Assistive Device/ Restraint Assessments dated 8/29/14 indicate; two full side rails and fall prevention related to use of low air loss mattress (per manufacturer's recommendation). This device restricts R37's freedom of movement and/or access to own body. All of the Assistive Device/ Restraint Assessments for R7, R9, and R37 also show the indication for Risks/Potential Negative Outcomes associated with use of device: Entrapment, Strangulation/Death, Decrease independence, and Decreased dignity. R11, R67, R84, R87 and R92 are additional residents who utilize two full side rails. All of the facility side rails are full. The Assistive Device/Restraint Assessments does not include the least restrictive alternatives attempted nor do	F 221		

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the plans of care include any type of reduction plans for all residents utilizing side rail devices.

On 9/12/14 at 9:40 AM during morning meeting E2 (Director of Nursing/DON) stated regarding the use of side rails: Restorative Nurses are the in process of re-evaluating residents listed as being physically restrained. We are looking into utilizing a different mattress to use on beds of residents who can get out of bed. We will be assessing and documenting the less restrictive device along with reduction plans.

4). Face Sheet documents that R81 was admitted on 2/26/2014, 81 years old with the following diagnosis: Convulsions, encephalopathy, abnormal gait, heart disease and dementia.

On 9/11/2014 at 11:25 AM, R81 was sitting in the room watching television. R81 said he was glad his bed was changed on 9/10/2014 because he had a problem with the full side rails. R81 said that he can get around but the side rails were hard to maneuver and it was difficult for him to get out of bed with the side rails up.

Assistive Device/ Restraint Review dated 2/26/2014, 5/28/2014 and 8/25/2014 all document due to R81's seizure precautions he was assessed to need two full side rails up while in bed.

Nursing Progress Note dated 9/10/2014 states, " Per staff, guest is not compliant with side rails in bed. Guest has seizure precautions per medical doctor ok to switch guest to a low bed.

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F 221	Continued From page 3 Nursing Progress Notes were reviewed from admission date of 2/26/2014 through 9/10/2014. According to the review of the notes R81 has had bilateral full side rails up times two from 2/26/2014 until 9/10/2014. On 9/11/2014 at 11:25 AM, E2(Director of Nursing) said " we just switched the bed out for R81. R81 said he did not like the side rails. I do not know everything about everybody. My two go to people are not here to help. R81 has seizure precautions. We now have him on low bed. He should have been on the low bed sooner. All of our beds have full side rails. We just have to get new beds." The Assistive Device/Restraint Assessment Policy dated 2/25/2009 states, " This program will not follow a set time table but will be adjusted according to each resident's progress in order to ensure a safe transition from the use of side rails to restraint free status. On 9/12/2014 at 9:49 AM, E2(Director of Nursing) said the facility will re-assess everyone on bilateral full side rails, re- educate the restorative nurses and implement less restrictive plans instead of the full side rails.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to follow their own abuse policy and procedure to protect, investigate and report an allegation of abuse alleged by one resident (R32). This is for one of two residents reviewed for allegations of abuse in the sample of 15.

The findings include:

Review of nursing note dated 8/9/14 at 8:30pm shows R32's stated her nurse's aide "that provided care at bed time threw her (R32), into bed and hurt her back. Afterward when providing care to her roommate, she stated the certified nurses aide rattled her side rails and kicked her bed. The writer did not witness the incident. The writer was in hallway at the medication cart. The Guest requested pain medication for her back pain." Documentation continues stating family and physician were notified and vitals charted.

E1 (administrator) stated on 9/11/14 at 10:10am, E1 is the abuse coordinator and conducts the investigations into such allegations. Review of facility allegations of abuse did not contain an investigation into this allegation. E1 stated on 9/11/14 at 11:00am he was not aware of this allegation and it had not been investigated.

As a result of staff not following the proper abuse allegation reporting procedures, this allegation of abuse was not investigated, the staff person involved was not removed while the allegation was being investigated and this allegation was not reported to the state.

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F 323	Continued From page 5	F 323		
F 323 SS=D	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 observation, interviews and record review, the facility failed to ensure side rails are safe and secure to prevent injury from occurring to 1 of 15 sampled resident R4 who sustained skin tears. The findings include: Record review on 9/9/14 showed R4 was readmitted to the facility on 7/23/14. The facility's assessment with the Minimum Data Set dated 8/18/14 shows R4's cognitive status as being interviewable (BIM'S) score of 14. On 9/9/14 at 11 a.m. a tour was conducted with E3 (nurse) who was assigned to the 100 unit. R4 was seated in wheelchair in her room and pulled the sleeve up on the right arm and showed a bruise she stated occurred when the arm became caught between the bed frame and side rail. R4 stated the arm was wedged so far down she could not get the arm out. R4 stated recalling being on the floor and yelling for help. R4 stated they had a hard time getting the right arm out of there and it caused the skin to tear. R4	F 323		

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complained of how awful it hurt and it still bothers her.

E3 who was present was asked about this incident. E3 stated it happened over a month ago and could not give details; but was aware it was caused from the right arm being caught between the side rail and bed.

On 9/9/14 the facility presented a list of residents names who use side rails and are considered a restraint. R4's name did not appear on this list.

E2 (director of nurses) on 9/9/14 at 3:40 p.m. was asked about the incident. A request to review the incident was made. E2 was asked, if R4 required the use of side rails/restraints? E2 stated , "No" and R4 did not use side rails. E2 stated the majority of the beds in the facility have bilateral side rails on the beds but are not used by the residents. E2 stated the facility has plans to acquire new beds. E2 stated if the side rails are removed from R4's bed it would leave sharp pieces of metal that would protrude from the bed that could cause cuts to the residents skin. E2 was asked to review the incident of 8/11/14 and how it occurred. E2 stated R4 was found on the floor and elbow was wedged in-between the left side rail,

On 9/19/14 at 3:40 p.m. R4's side rails and bed was examined with E2. E2 stated not being able to understanding how R4's arm could become wedged in between the bed as the resident went down onto the floor. R4 was present and seated in a wheelchair during this time. E2 sat on the left side of the bed and slowly slid down toward the floor. As E2 slid, the side rail was observed to bow out away from the bed frame. This created a

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F 323	Continued From page 7 gap about four inches between the bed and bed frame. E2 was able to extend the left arm and elbow into this space. Review of the nurse progress note for 8/12/14 show at 11:45 p.m. on 8/11 show a CNA E5 (certified nursing assistant) found R4," sitting on the floor", stating, "Help me" arm was wedged in between the bed frame...upon trying to unwedge R4's arm it caused a few skin tears" on 8/11/14 at 11:45 p.m. There was no assessment or description or the number of the skin tears that occurred to R4. On 9/11/14, E 2 was asked for an assessment of R4's skin tears that occurred on 8/11/14. E2 stated the assessment information was documented in the nurse progress notes. Review of the notes found there was no assessment documented. On 9/10/14 at 12 p.m. during a meeting with E1 (administrator) and E2, they collaboratively discussed the following issues: the side rails on R4's bed and studs were removed on the evening of 9/9/14 and all of the beds in the facility were checked for loose moving side rails and no others were found. On 9/12/14 at 11 a.m. R4 was seen being ambulated outside the physical therapy room with E4 (physical therapist). R4 stated feeling better and no longer afraid of getting her arm getting stuck because the side rails have been removed from her bed. E4 said R4 has lymphedema of the lower legs and because of this when R4's side rail are down they stick out away from the bed and sometimes would cause R4's to bump and hurt her leg on it.	F 323		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 8 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide rationale for continued usage of anti-psychotic medication for one (R2) of five residents reviewed for anti-psychotic medication in the sample of 15. Findings Include: R2 admitted on 6/11/2013, is 83 years old with	F 329		

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the following diagnosis: abnormal posture, generalized weakness, heart disease, depression, paranoid state, abnormal posture and hypothroidism.

On 9/9/2014 at 2:25 PM, R2 was sitting in a wheelchair in his room. R2 calmly stated he was ok.

On 9/10/2014 at 8:43 AM, R2 was propelling himself from the dining room back to his room. R2 was calm and cooperative and said that breakfast was good and that he was going back to his room.

Pharmacy Facsimile dated 7/15/2014 states, "gradual dose reduction is due for Risperdal .5 milligrams every day. Originally ordered 9/2013. No behaviors issues. Can we attempt a reduction to Risperdal .25milligrams everyday if not please give a rationale."

Physician Orders were reviewed from July of 2014 until September of 2014. The orders state R2 has been on Risperdal 0.5 milligrams from September of 2014 and reduced on 7/15/2014.

Psychotropic Drug Review Form dated 9/20/2013, 12/18/2013, 4/9/2014, and 7/9/2014 all document no behavior issues, alert friendly and cooperative. The Psychotropic Drug Review Form dated 12/18/2013 states, " reduce to .25 milligrams due to no behaviors." According to Physician Orders the reduction did not occur until 7/15/2014(7 months later).

On 9/10/2014 at 10:25 AM, E2(Director of Nursing) said the assistant director of nursing was in charge of psychotropic drug reductions

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and she is no longer employed here. " I do not know what happened with R2's drug reduction. R2 should have been reduced sooner, R2 should not be on psychotropic at all but the doctor will not reduce even though R2 has no behavior issues. R2's primary doctor does not like to reduce psychotropic drugs, does not give a reason for continued use and does not allow the residents to see a psychiatrist."

Psychotropic Drug Usage Policy revised on 11/1/2013 states, "7. All psychotropic medication usage will be assessed for patient response and possible dosage reduction according to the state and federal guidelines or at least quarterly. Residents should receive gradual dose reductions and behavior interventions in accordance with state and federal guidelines with results clearly documented in the nurses' notes. If dose reduction is not feasible or prove to be unsuccessful, the nurse and the physician need to document reasons and rationale on their progress notes."