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F 323	Continued From page 21 1. On 9/7/07 all residents with any type of side rail was re-assessed. 2. On 9/7/07 facility policy regarding restraint devices was reviewed. 3. On 9/12/07 facility staff was in-serviced on facility policies regarding use of side rails and the possible dangers to residents. 4. On 9/13/07 residents considered most vulnerable were assessed regarding the concerns and benefits of side rails. Permanent or temporary measures to further reduce the danger of side rails. 5. Charge nurses will provide increased surveillance along with line staff. 6. Residents with side rails will receive further assessment to implement or trial less restrictive/safer interventions.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)2)3) 300.3240a) 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.	F9999		

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F9999	Continued From page 22 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 23 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS were not met as evidenced by: Based on record review, observation and interview the facility failed to thoroughly assess for alternative measures, identify safety risks, identify medical symptoms and conduct a gradual and systematic reduction for use of a side rail for one (R3) of four residents reviewed with side rails. This failure resulted in R3 falling from bed and getting her head caught in the half rail which resulted in hospitalization and a fracture of the C1 spine. Findings include: 1. R3 was admitted to the facility on 4/1/03 with diagnoses, in part, of diabetes type 2, cerebral vascular accident with left hemiparesis, dysphagia, myocardial infarction, severe dementia, and depression with psychosis. R3 was assessed on the most current Minimum Data Set (MDS) of 5/21/07 with severely impaired cognitive skills with short and long term memory problems. R3 was also assessed as extensive assist with one person physical assist for bed mobility and extensive assist with two person physical assist for transfers. The MDS identified that R3 had two full side rails and the bed rails were used for bed mobility or transfer. R3 was identified as lifted manually or with a mechanical lift. On 7/2/07 and 8/4/07 R3 was assessed on the	F9999		

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"Fall Risk Assessment" as a 12 or high risk for falls. The care plan dated 8/21/07 documented "Safety: I am at high risk for falls R/T medication usage, require assist with transfers." One of the approaches stated that R3 had "side rails up x 2" however this was crossed out and dated 8/10/07 with a new entry of "No rails @ this x" made. On 8/27/07 the care plan was updated on 8/27/07 and stated "rolled out of bed 1/2 rails applied (with) safety mat on floor."

On 8/10/07 R3 was assessed on the "Side Rail Assessment Form" and it was identified that R3 did have the following concerns: lower extremity problems, safety awareness alterations due to cognition, displayed poor bed mobility, had difficulty with balance, could move in bed without staff assistance "minimal," was not immobile or unable to change position in bed, did not use the rails for positioning, support or to assist with mobility, was not restless or attempt to get out of bed with assistance, and there is a potential for injury related to involuntary movements when in bed. No medical symptom was identified for the use of the full rails.

Under the section of the "Side Rail Use Assessment Form" that identified alternative or supportive measures to use it identified that R3 would benefit from frequent staff monitoring, assistance with toileting when in bed, and visual and verbal reminders to use the call bell. Other alternative measures noted such as sensor alarms to bed, bed bolsters, low bed, body pillows or floor mat next to bed were not checked. There were no least restrictive measures documented. Under the section "Risk vs Benefit of side rail use" noted that there was no benefit of side rail use and the risk was

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"entanglement/strangulation." Under the section "Determination of Side Rail Use" it was noted that side rails did not appear to be indicated at this time. On 8/10/07 the bilateral full side rails were discontinued.

According to the "Resident Fall Report," dated 8/27/07 at 7:30 PM, R3 was found lying face down on the floor next to the bed. The roommate, R10, reported R3 rolled out of bed. R3 sustained a "golf ball size hematoma to R side forehead-bruising to start." The fall report identified potential causes of the fall as not asking for assistance, not using the call light, decreased safety awareness and confusion. The report identified "Recommendations for Interventions" as "1/2 bed rails x 2, safety mat on floor, and O.T. seeing for positioning in chair." The "Resident at Risk Assessment and Tracking Form" dated 8/30/07 documented the possible causative factors for the fall as "no side rails."

In an interview with E2, Director of Nursing, on 9/10/07, she stated that the 1/2 rails were put up and the safety mat put on the floor after the first fall on 8/27/07. The bed remained at normal height and was not lowered due to the use of the mechanical lift and arthritis in R3's knees made it difficult for her to get up from a low bed.

The "Side Rail Use Assessment Form" dated 8/10/07 was updated on 8/28/07, and noted that there was a change in assessment due to "#17 potential for fall-rolled OOB 8/27/07." Under the section that states change related to determination of side rails use it states "1/2 rails (with) safety mat on floor."

The "Resident Fall Report," dated 9/6/07 at 11:50

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PM, documented that R3 was "found on mat next to bed with head between S/R (1/2) and mattress." The report states R3 had a large lump on her right hip, left neck and cheek were very red. R3 was sent to a local hospital emergency room and then transferred to a metropolitan hospital. R3 sustained a "C1 fx" of the spine.

In an interview with R10, roommate to R3, she stated she was in bed on 9/6/07 and heard noises coming from her roommate's side of the room. R10 stated she was in bed and had the curtains pulled so she could not see R3. R10 stated she heard R3 say "I need help" so R10 put on her light and then yelled for the nurse. R10 stated R3 usually laid still in bed but had scooted to the edge of the bed several times so that R10 told her to get back. When asked if R3 could roll in bed by herself R10 stated she guessed she could as she fell out of bed twice by herself. R10 stated R3 was twisted and it looked like her neck was broke on 9/6/07.

In an interview with E3, Certified Nurse Aide, on 9/11/07 by phone, she stated that she had last seen R3 laying in bed about 11:00 PM. E3 stated R3 was laying on her back. E3 stated that the call light was on and then she heard R10 screaming for help. E3 stated when she entered the room R3 was off the bed with her legs on the safety mat. E3 stated that R3 was hanging from her head and her head was caught between the rail and the mattress. E3 stated R3 was on her knees but it was obvious that she was not supported by her knees. E3 stated the only reason R3 was staying up was because her head was in the rail. E3 stated R3's chin was in the first space of the side rail. E3 stated she had to lift R3 up to get her out of the rail and had a hard

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time getting her out. E3 stated she picked R3 up out of the rail and laid her on the mat. E3 stated R3 face was red and her eyes locked on her like she was froze. The nursing notes dated 9/6/07 noted that R3's left cheek and neck were very red and R3 was short of breath and oxygen was applied. E3 stated she asked R3 if she was OK and then she said yes. E3 stated she had seen R3 roll side to side if she was helping her but had not seen her move herself. E3 stated other staff had said they had seen her move in bed. The side rail was observed in R3's room. The metal half rail had vertical spaces 3- 4 inches apart in the rail itself. There was no padding on the rail.

In an interview with E9, Clinical Operations Manager, on 9/11/07, he stated that the team had used the "Side Rail and Alternative Equipment Intervention Decision Tree" after the first fall to make a decision on what interventions to use, and the half rail with a mat on the floor was decided upon by the team. The form states if a resident has rolled out of bed to refer to the team for one or more interventions. These interventions include: "mattress with raised edges, boundary reminders (body-length pillows, rolled blankets, or children's "swimming noodles" (foam flotation aids) under mattress edges, and 1/2, 3/4, or full length SR's with narrowly spaced inner bars, fitted flush to mattress with SR pad or pillow." On the first fall R3 did not have side rails and the decision tree states "Does the patient attempt to get out of bed unsafely (climbs over or around SR or foot of bed). E9 stated because R3 did not try to go over the side rail they did not follow that intervention for R3 which stated to "Refer to team for one or more interventions: low...or very low -height bed.., mat(s) at side of bed, body-length or other pillows, motion-sensor

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light, bed alarm."

In an interview with E8, Certified Nurse Aide, on 9/11/07, she stated R3 could roll herself in bed and turn side to side. E8 stated R3 would also help staff to move side to side. E8 stated R3 may have been more active at night as she slept a lot during the day.

In an interview with E7, Physical Therapy Aide, on 9/11/07, she stated that therapy had worked with R3 a few months ago. E7 stated that they had walked with her but she would only go a few steps. E7 stated R3 could roll in bed by herself.

E6 was interviewed on 9/11/07 and stated occupational therapy was asked to see R3 after she fell from bed the first time. E6 stated R3 was not moving and had the half rails so they thought she was safe. E6 stated that they did not consider any other alternatives such as bed bolsters or scoop mattress as R3 had the half rails. The Occupational Therapy "Weekly Progress Note/Discharge Summary" dated 8/30/07 states that "pt fell out of bed nsg) (secondary to) no siderails. Pt now has 1/2 rails to increase safety. pt appears to be safe in bed." The summary notes that R3's bed mobility was not assessed. E2 stated on 9/11/0 that she had ordered a scoop type mattress on 9/11/07.

R3 was readmitted to the facility on 9/12/07 with diagnoses of C1 fracture with C1-C2 sublaxation. The CT scan dated 9/7/07 identified that R3 had a "C1 burst fracture, without apparent spinal cord involvement." R3 was readmitted to the facility on hospice services. The hospital "History Progress Notes" dated 9/10/07 states that "despite high

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mortality rate with conservative approach; given the pt's poor functional status; i.e.. bedridden and comorbidities it was decided to go with conservative approach; i.e. collar." On the hospital "TSL Progress Note to Withhold or Withdraw Life-Sustaining Treatment" it stated "With C1 fracture and C1-C2 sublaxation at high risk of sudden death if surgery will not be done." The note states R3 did not want surgery and would request hospice care.

(A)