STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	802 2ND ST NW BOWMAN, ND 58623

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on December 12, 2016 and completed on December 14, 2016, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §482.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive	F 221		12/29/16

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

Electronically Signed | 12/30/2016

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F 221	Continued From page 1 alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from physical restraints not required to treat their medical symptoms for 1 of 1 closed record resident(Resident #10) with wedges placed while in bed. Failure to evaluate the potential of wedges becoming a restrictive device for Resident #10 resulted in a fall with bruising/skin tear. Findings include: Review of the facility policy "Definition of a Restraint" occurred on 12/14/16. The policy, revised 07/15/15, stated, ". . . 'Physical Restraints' are defined as any . . . material or equipment . . . adjacent to the resident's body . . . which restricts freedom of movement . . ." Review of Resident #10's medical record occurred on December 12-14, 2016. Diagnoses included transient ischemic attacks (TIAs), anxiety, depression, and falls with femur fracture. Resident #10's current care plan stated, ". . . [Resident #10] . . . is at risk for falls. . . . Bed wedges on bed under mattress and pillows under sheet on both side [sic] so [Resident #10] is aware of her bed boundaries [created 07/18/16]. . . ." The physician's orders, dated 07/18/16, identified, ". . . Top half siderails up when in bed	F 221	1. The resident that had bed wedges in place is no longer a resident at SHS. 2. Current residents: 3 out of 37 residents have bed wedges in place. Bed wedge assessments were performed to determine if the bed wedge is being used as a restrictive device. The assessments concluded for all of the 3 applicable residents that they are indicated and serve as a security boundary, resident has expressed desire to have bed wedges, and the bed wedge is not a restrictive device. Bed wedge assessment/s will further be performed quarterly by DON/Designee to determine if the bed wedge is still appropriate. Discussion will also be held with the Interdisciplinary Team at least monthly regarding use of bed wedges. 3. Any newly admitted or current resident with potential for wedge use: Prior to any new use of a bed wedge, bed wedge assessments will be performed by DON/Designee to determine if the bed wedge is used as a positioning/boundary tool or as a restraint. If the bed wedge is determined to be a restraint, other alternatives will be looked into. Thus, bed wedge will not be used. Staff will be informed of intervention changes and intervention changes will be documented	

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F 221	Continued From page 2 to aid in bed mobility and repositioning. . . ." The orders failed to identify the physician was in agreement that wedges should be utilized when Resident #10 was in bed. The quarterly Minimum Data Set (MDS), dated 07/19/16, failed to identify the use of wedges by marking section P: Restraints on the MDS. Progress notes identified the following: * 07/10/16, The facility transferred Resident #10 to a local hospital for hypotension, weakness, and edema. * 07/12/16, Resident #10 returned to the nursing home following discharge from the hospital. * 07/15/16, "Resident rang several times today and at times did know [sic] know what she wanted. . . . she requested to go to bed but is helped there and then she wants up staff has [sic] told her to ring her call beel [sic] for help but at times staff has [sic] found her sitting on bed edge. . . . Resident was agitated & [and] restless . . . She tried getting out of bed & was screaming. . . ." * 07/18/16, ". . . [Resident #10] has had 2 falls with no injuries. Wedges have been placed so [Resident #10] will know the boundaries of her bed since she will throw her legs over the bed. [Resident #10] is not aware of her safety needs and will attempt to self transfer at times. . . ." * 07/22/16, ". . . Resident pushes the wedges off of the bed, and she sits on the side of the bed. Cna found her sitting there, and went in to help put her legs back in the bed. . . ." * 07/23/16 at 12:34 a.m., ". . . Resident has been ringing a lot this HS. She sits up on the side of the bed. . . . She pushes the wedges off of the bed, and continues to sit on the side of the bed." .	F 221	on the care plan. Staff education on 12/29/16. DON or designee will review each of the assessments as listed in number 2 & 3. If the following are not met: serve as a security boundary, resident has expressed desire to have bed wedges, and the bed wedge is not a restrictive device; the devices will be discontinued at time of assessment and at any time this criteria is not met. 4. The DON or designee will do assessment/s and any needed action weekly x4, monthly x2 and quarterly x4. Results will be submitted to the QA committee by the DON or designee quarterly for four quarters. 5. 12/29/16	

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F 221	Continued From page 3 . . at 2:40 a.m., ". . . Resident was yelling for help, she was found with her legs under the bed, sitting up by holding on to the bed rail. She was trying to get out of bed by herself. She had spilt her water all over the floor. The wedge and two of her pillows were on the floor with her. She was bleeding a little from an old skin tear on her right elbow . . . Resident had been given Clonazapan . . . with no results. She has been ringing her call light and then denying that she had done it. She was restless and ringing the light to get someone to answer her light for no real purpose." . . . at 5:27 a.m., ". . . Resident was just yelling help. I found her sitting on the edge of the bed, with her legs over the bed wedge. If she had slid any further she would have been on the floor again. I told resident that she needs to lay down and get some sleep." . . . at 6:33 p.m., ". . . Resident requested to lay down for a couple of min [minutes]. Staff told her she needed to stay in w/c [wheelchair] as she has been trying to get up self and fell last night. . . . Resident has been ringing a lot this HS [hour of sleep] . . . She wanted to go to bed, I tild [sic] her she should sit in her chair, she said I was a pain in the ass. . . ." A "Resident Fall Review," dated 07/23/16, further identified, ". . . Staff heard Res [resident] call out/help. Found/floor of room legs under the bed, holding onto the bed rail Water spilled/floor, wedges on floor. Reopened a skin tear to R [right] elbow. States she was trying to get out of Bed by herself, but unsure why. . . . 07/26/16 Bed wedges [under] mattress on each side, pillow [under] sheet on each side so Res aware of Bed boundaries. . . ." Progress notes identified the following:	F 221		

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F 221	Continued From page 4 * 07/25/16, Resident has been ringing her call light frequently through-out this shift. Staff go in to answer her light and she will either not need anything or will have forgotten what she was ringing for. . . ." * 07/26/16, "Resident has been yelling while other residents are trying to sleep. She has tried to get out of the bed times 3 . . . Cna's had to go into her room and put her back up in bed and rearrange the wedges as she was trying to get out of bed. She stated, 'what are you doing, putting them back in so I can't get out of bed.' . . . Resident wants to get up, lay down, get up, lay down, she does not know what she wants. . . . Finally we toileted her and laid her in bed putting wedges under the mattress and under the bottom sheet. . . . Bed wedges under mattress on each side. Pillow under sheet on each side so [Resident #10] is aware of her bed boundaries. . . ." * 07/27/16, ". . . Cna just checked on resident and then she left the room, and [Resident #10] started yelling 'help me' Help me' for no reason. Resident said she didn't want anything. . . . Resident was found with her legs thrown over the bed wedge. She was put back in the bed. . . ." * 07/30/16, ". . . Requested and received tramadol [an analgesic] @ [at] 1130 after getting O.O.B. [out of bed] and going to the bathroom first. . . ." The note did not indicate wedges had been placed in the bed. * 08/01/16, ". . . [Resident #10] had a fall on 7/9/16. Bruises noted the next day. [Resident #10] is frequently confused and states that she is able to walk by herself. She has no safety awareness. Bed wedges in place to serve as boundaries on her bed since she will throw her legs off of her bed. . . ."	F 221		

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F 221	Continued From page 5 * 08/07/16, Resident #10 expired. During an interview on the morning of 12/14/16, issues pertaining to the use of wedges were discussed with administrative staff members (#2 and #4). The administrative staff members stated if a resident is able to get out of the bed, the use of wedges would not be considered a restraint. Since they did not consider the wedges a restraint, they did not complete a restraint assessment. They further stated the wedges were used to alert [Resident #10] of the bed boundaries. When asked why the facility did not lower Resident #10's bed and/or utilize a fall mat, the administrative staff members (#2 and #4) stated, "Lowering [Resident #10's] bed would restrain her, as she wouldn't be able to get out of bed then." When asked why the facility did not obtain an actual perimeter mattress for Resident #10, the administrative staff members (#2 and #4) indicated the only perimeter mattress within the facility was already being utilized by another resident. When asked if the facility could purchase a second mattress, they stated, "That would have to be discussed with Administration." The facility failed to assess the potential of the wedges placed in Resident #10's bed becoming a restrictive device.	F 221		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		1/15/17

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F 323	Continued From page 6 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: OXYGEN TUBING 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide a safe environment for 1 of 1 closed record resident (Resident #10) whose oxygen tubing posed a tripping hazard. Failure of the facility to ensure Resident #10 was provided a safe environment resulted in a fall with femur fracture and a second fall. Findings include: Review of the facility policy "Assessing Falls and Their Causes" occurred on 12/14/16. The policy, revised October 2010, stated, ". . . Approximately 50 percent of residents fall annually and 10	F 323	F 0323 Free of Accident Hazards/supervision/devices: Side Rails 1. A side rail cover will be placed over the side rail of the resident involved. 2. 15 out of 37 residents have a side rail or side rails in place. All residents with side rails will have a side rail assessment completed. Results from the 15 side rail assessments gave evidence of transfer status, type of rail required and reason for recommendation. None of the completed 15 assessments indicated bed rail use impedes resident freedom of movement or bed rail precluded resident access to his/her body. Consents will be obtained for those residents that will have side	

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F 323	Continued From page 7 percent of these falls result in serious injury. . . . Falling may be related to . . . environmental risk factors. . . . Resident must be assessed in a timely manner for potential causes of falls. . . . Relavent environmental issues should be addressed promptly. . . ." Review of Resident #10's medical record occurred on December 12-14, 2016. Diagnoses included transient ischemic attacks (TIAs), anxiety, and falls resulting in a femur fracture. The quarterly Minimum Data Set (MDS), dated 07/19/16, identified a history of falls; one with injury. The physician's orders, dated May 2016, identified, ". . . Oxygen to keep above 92% - currently at 3 liters. . . ." The care plan stated, ". . . [Resident #10] . . . is at risk for falls. . . . [Resident #10] insists on ambulating in her room independently without the use of a walker. Staff are to assist [Resident #10] with ambulation outside her room by following her with the portable oxygen tank. [created 12/31/15]. . . ." The progress notes identified the following: * 12/15/15, Resident #10 was admitted to the nursing home. * 12/18/15, ". . . Resident also noted to be walking over O2 [oxygen] tubing and tubing gets between legs. Attempted to assist resident with O2 tubing management, but she became upset . . ." * 12/20/15, ". . . Resident has been observed walking in her room without assistance. She has been encouraged to call for assistance, but	F 323	rails. 3. All residents with side rails will have a mesh covering or alternative device as recommended by the manufacturer. Staff will be informed of each resident side rail usage and device placed to the side rail. Staff will be informed of intervention changes and side rail placement and/or device will be documented on each resident care plan. Discussion of side rails will be held by the interdisciplinary team monthly. If the side rail assessment and/or IDT discussion indicates the bed rail use impedes resident freedom of movement or bed rail precluded resident access to his/her body, the side rail usage will be discontinued. Also if the side rail no longer meets reason for side rail places: safety, fear of falling, fear of injury, wandering, illness, increased bed mobility, increased independence, then the side rail will be discontinued and other alternatives investigated. 4. Side rail assessments will be performed weekly x4, monthly x2 and then quarterly x4 and with significant resident change by the DON or designee. QA results will be reported by the DON at quarterly QA meeting for four quarters. 5. 1/15/17 F □ 0323 Free of Accident Hazards/supervision/devices: Chemicals The resident environment will remain as free from accident/ hazards as is	

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F 323	Continued From page 8 states that she does not need help. She has poor safety awareness with O2 tubing management, as she has been observed getting tubing tangled around her legs and waist. . . ." * 12/26/15, ". . . Resident was observed walking in her room without using her walker, as she is using it as a clothes hanger for slacks she wants to wear in the morning. She then walked through her O2 tubing on the floor, entangling her feet in the tubing, but not making any attempt to untangle her feet, so nurse did this. . . ." * 01/29/16, ". . . PT [Physical Therapist] explained that she has the O2 tubing to be conscious of and if she would get caught up in that, she would have nothing to steady her if she were to fall. . . . She is willing to continue to call for help to have someone push the portable O2 tank in the hall when she walks with her walker, but is frustrated that she has to be "obligated to call someone." PT educated on the need for a walker and O2 due to the fact that nursing did try to take O2 off and she dropped below 90%. She is at times dizzy and unsteady. She has had troubles navigating the O2 tubing multiple times with staff present. . . ." * 01/04/16, ". . . Resident observed walking in hallway without walker or assistance. She was cued because she had O2 tubing wrapped around her left foot, and she then untangled the O2 tubing. . . . Attempted to educate about importance of safety measures to prevent any falls and injuries, but resident does not agree that she needs to follow any of these measures. . . ." * 04/11/16, Resident #10 was hospitalized for a urinary tract infection [UTI]. * 05/23/16 at 6:56 a.m., ". . . At 03:45, heard a voice calling, 'help me, help me' . . . resident was lying tilted on her R [right] side with oxygen	F 323	possible. 1. Cabinet that stores chemicals in the Unit 1 and Unit 2 tub room was checked to assure that the locks to the cabinets are in working order and are locked when not in direct supervision. Signage present on each tub room door stating to keep door closed. 2. All residents go to the tub room on Unit 1 or Unit 2 for bathing. 3. Signage has been placed on the cabinet on each unit that stores chemicals. Signage also placed on the back of each tub room door as a reminder. Staff will be educated at the Nursing Staff Meeting on 12/29/16. 4. Cabinets in each tub room will be checked daily x2 weeks by the DON or designee to assure that they are locked. Thereafter, the tub rooms will be checked 10 times per month by the DON/Designee. The door to each tub room will be checked daily x2 weeks by DON or designee to assure that they are closed when not in use. Thereafter, they will be checked 10 times per month by the DON or designee. QA results will be reported by the DON at the quarterly QA meeting for four quarters. 5. 12/29/16 F □ 0323 Free of Accident	

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F 323	Continued From page 9 tubing curled around her: her head was between the wall of the closet and her personal nite [sic] stand with drawers; drawers have protruding handles on them; raised her to a sitting posisiton, 3 assist with GB [gait belt] to stand her and assist a few steps to her bed. . . . Resident stated she was returning from the bathroom when she fell. When asked what she thot [sic] caused her fall, she stated, she 'tripped but thot [sic] she could catch herself'. She couldn't say what she tripped on, but long oxygen tubing was laying all around her. . . . Notes small abrasion to back of R side of head; measures 0.4 cm [centimeters] x 0.2 cm; bruise to R lateral upper arm; measures 3 cm x 10 cm with an abrasion in the center of 1.5 x 3. There are several scattered bruises around her R elbow, and one larger bruise on the lateral R forearm, distal to the elbow, measures 4.5 cm x 2.7 cm. When resident stood up, Rt [right] leg buckled; resident stated she thought she cracked her knee cap. . . . several minutes later wanted an X-ray on the hip." . . . at 7:59 a.m., ". . . A few minutes later, she asked to go to the bathroom . . . GB applied with 2 assist to stand her from the EOB [edge of bed]; again her R leg buckled . . . When back to bed, she was rubbing her lateral rt thigh" . . . at 12:23 p.m. . . . " resident had an appointment at 9:00 [a.m.] [with]/. . . [nurse practitioner] due c/o [complaints of] pain in right leg/hip area. . . . Phone call from . . . [nurse practitioner] stated that resident was sent to Bismarck due to r hip fracture. . . ." A "Resident Fall Review," dated 05/23/16, identified, "Res [resident] call out 'help me'. Found/floor on R side, tangled/O2 tubing. Abrasion to head & R shoulder. Bruise R elbow & thigh. . . . Res states she was up to BR	F 323	Hazards/supervision/devices: Oxygen Tubing The resident environment will remain as free from accident/ hazards as is possible. 1. Resident # 10 no longer resides at Southwest Healthcare Services -LTC. 2. Eight out of 37 residents currently use limited portable oxygen. One resident only uses 02 when in bed or chair. The 02 is removed with ambulation per resident. All other residents have assistance with mobility and 02 equipment; thus no current independent residents with portable 02. 3. All newly admitted independent residents or residing residents, who use portable 02, will have a Resident Safety with Oxygen Tubing Assessment done by the DON or designee, upon admission, with any physical or mental changes, accidents and variances and at least quarterly. Policy reviewed and revised. DON or designee will monitor Progress Notes of any residing independent resident who uses portable 02 for any physical and/or mental changes, accidents or variances that would deem a safety risk at least weekly. The DON or designee will evaluate the current interventions and make changes tailored to each resident. Staff will be informed of intervention changes and intervention changes will be documented on the care plan. Possible interventions on the	

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F 323	Continued From page 10 [bathroom], tripped & could not catch herself. . . . Contributing Factors: . . . . O2 tubing curled around Res/noted [with] Res on floor. . . . LPN [licensed practical nurse] suggested she use light above bed in the future. Call light was accessible. [No] trip hazards - other than O2 tubing. . . . Consulted [with] . . . Therapist for possible device to [reduce] trip hazard/O2 tubing. No conclusive device [at] this time. Return to LTC [long term care] 05/31/16. . . . 06/07/16 - Coil O2 tubing being used to [decrease] fall risk r/t [related to] tubing. [Increased] urinary incontinence, vesicare started. . . ." The report also listed medication changes and "OT [Occupational Therapy] offered Tx [therapy] option r/tshoulder arthritis" as additional interventions the facility implemented prior to the fall. The progress notes identified the following: * 06/07/16, ". . . New O2 tubing switched out, so as to prevent resident from tripping. tubing is coiled and can clip on to her clothes, much less of a trip hazard. . . ." * 06/08/16, ". . . She also complained of not liking the new O2 tubing because it 'doesn't give.' . . ." * 06/09/16, ". . . She continues to complain about her O2 tubing and states, 'that does not work.' . . ." * 06/15/16, ". . . Results positive for UTI . . . She does need SBA [stand-by assist] for ADL's [activities of daily living] and mobility for safety, as she does have limitations with her safety awareness. . . ." * 06/17/16, "Resident was able to sit and stand without manual assistance, but she was not able to negotiate O2 tubing and sat very impulsively due to SOB [shortness of breath]. She is not able to go to the BR [bathroom] on her own without	F 323	Resident Safety with Oxygen Tubing Assessment may include, but not all inclusive: length of 02 tubing, color tubing for visual acuity deficit, urinal and bedside commode, scheduled toileting plan, hourly rounding. 4. Currently there are no independent residents with portable 02. When a resident is admitted or a residing resident becomes independent with the use of 02, the DON or designee will report their QA findings utilizing the QA: Oxygen Safety for the Independent Resident form. QA will be done weekly x4, monthly x2 and quarterly x4. Findings will be reported by the DON to the Quarterly QA Committee for 4 quarters. 5. 12.29.2016	

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supervision and help with O2 tubing. RN [registered nurse] notified. . . . resident does remain at great risk of fall. . . ."
* 06/18/16, ". . . CNA's found resident sitting on the floor @ [at] 2120 [9:20 p.m.] Resident said she took herself to the bathroom & on her way back, she tripped over the oxygen tubing & she lost her balance & landed on the floor. On assessing her, no new bruises, skin tears or abrasions noted. . . ."

A "Resident Fall Review," dated 06/18/16, identified, "CNA [certified nursing assistant] found Res sitting/floor of room. Res states she was returning to bed from BR, tripped on O2 tubing = fall. . . . Contributing Factors . . . O2 tubing . . . Environmental Factors . . . O2 tubing . . . 06/07/16 Coiled O2 tubing triales, R/T fall risk. Res used until 06/13/16 - as Res refused - c/o tubing coil too tight & pulls on her. Returned to regular O2 tubing. . . . Res's condition likely contributed to fall: UTI, urinary urgency, pain/meds, new medications. O2 tubing also contributed - trialed coiled O2 tubing, but Res refused [after] 6 days. . . ."

During an interview on the morning of 12/14/16, issues pertaining to the O2 tubing were discussed with administrative staff members (#2 and #4). The administrative staff members stated the various interventions the facility attempted were listed on the fall reports. Based on review of the fall reports, interventions were initiated only after Resident #10 fell and fractured her femur.

Failure of the facility to ensure Resident #10 was provided a safe environment resulted in her fall with femur fracture and a second fall. The

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medical record identified staff were aware Resident #10 was impulsive, showed poor safety awareness, and was unable to manage the O2 tubing herself. Staff observed Resident #10 "walking over the O2 tubing and becoming entangled in the tubing (around her feet, legs, and waist)" on several occasions. The facility reported implementing medication changes and referred Resident #10 to OT for shoulder arthritis in an effort to reduce her fall risk. Following Resident #10's fall with femur fracture, the facility reported they trialed an O2 tubing coil for approximately six days, until the resident refused to use it.

USE OF SIDE RAILS

2. Based on observation, record review, facility policy and staff interview, the facility failed to assess the use and/or need of side rails for 1 of 5 sampled residents (Resident #1) with a fall from the bed and arm entrapment in the side rail without injury. Failure to assess the use and/or need of side rails placed Resident #1 and other residents at risk for injury and entrapment.

Findings include:

Review of facility policy titled. "Proper Use of Side Rails" occurred on 12/14/16. This policy, revised 7/20/2015, stated, "Purpose, The purpose of these guidelines are to ensure the safe use of side rails as residents mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms . . . General Guidelines, . . . 3. An assessment will be made to determine the resident's symptoms or reason for using side

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rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. bed mobility; and b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet. . . . 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. 8. The risks and benefits of side rails will considered for each resident. 9. The resident will be checked periodically for safety relative to side rail use . . . "

Review of Resident #1's medical record occurred on all days of the survey. Diagnosis included fracture of unspecified part of neck of left femur and presence of left artificial hip joint. A Significant Change Minimum Data Set (MDS), dated 08/12/16, identified extensive assist of two for bed mobility and transfers. The current care plan stated, ". . . Focus: . . . at risk for falls . . . Reposition when in bed every 2 hours and prn . . . Left side rail up when in bed to aid in positioning . . . "

Review of Resident #1's progress notes identified the following:
*08/09/16 at 2:31 p.m. " . . . Resident had complication after surgery with oxygen levels and confusion."
*08/10/16 at 3:43 p.m., "At 0610 nursing alerted by housekeeping that resident was on the floor. Upon entry into the room, resident found in sitting position on his right hip with both legs bent out to his left. his right arm was trapped between the side rail and mattress, with his back against the bed. Side rial lowered so resident could free his right arm. Initially he said it hurt, but then said it didn't. No new injury or deformities noted. . . .

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F 323	Continued From page 14 Unable to say how he ended up on the floor." Review of Resident #1's "Resident Fall Review", dated 08/10/16, stated, " . . . Lethargy, confusion noted upon return to LTC (Long Term Care), . . . Reviewed SR (Side rail) usage. Resident requested to remain for positioning from side to side." Observation on 12/13/16 at 9:00 a.m., showed a physical therapist (PT), (#1) evaluating Resident #1's ability to go from a seated position to lying in bed and back again. The PT cued Resident to lower his upper body on to his left side and lift legs into the bed. The PT then cued Resident #1 to roll on to his left side, lean on his elbow, and push himself to a seated position by pushing upward with left elbow and right hand. Resident #1 was able to complete both tasks given cueing and encouragement without the need of a side rail. The side rail reamined on the bed and on the careplan even though the resident demonstrated the ability to reposition without the use of the siderail. During an interview on 12/14/16 at 9:50 a.m., a physical therapy staff member (#1) identified the decision to use side rail was based on what the resident was doing prior to his surgery. She stated "Resident #1 was independent," and "we do not use bed rails unless we have to." During an interview on 12/14/16 at 10:25 a.m., an administrative nurse (#2) identified the occupational therapy department previously completed side rail assessments. She confirmed no side rail assessment had been completed after Resident #1's arm got caught in the side rail	F 323		

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F 323	Continued From page 15 on 8/10/16.	F 323		

Review of Occupational Therapy notes and Physical Therapy notes dated 8/10/16 - 9/20/16 do not identify use of a side rail for Resident #1.

Review of Resident #1's progress notes from 08/10/16-12/13/16 showed no further incidents of entrapment in the side rail occurring.

UNSECURED CHEMICALS

3. Based on observation and review of Material Safety Data Sheets (MSDS), the facility failed to maintain an environment free of hazardous chemicals for 1 of 2 bath houses (Unit 1 Bath House). Failure to secure hazardous chemicals placed cognitively impaired and wandering Residents at risk for accidents/injuries.

Findings include:

Review of the MSDS Sheet for Buckeye Sanicare Quat-256 stated, " . . . Corrosive. Causes irreversible eye damage and skin burns. Harmful if swallowed or inhaled . . . "

Review of the label on the CEN KLEEN IV on 12/13/16 stated, " . . . Danger: Corrosive. Irreversible eye damage and skin burns . . . "

Observation on 12/13/16 at 4:20 p.m. showed the Unit 1 Central Bath House with the door wide open and a sign on the door stating, "Keep Door Closed". A cupboard in the Unit 1 Central Bath House was unlocked and contained a bottle labeled Quat that was not in its original container

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F 323	Continued From page 16 and a jug of CEN KLEEN IV. The facility failed to secure hazardous chemicals to maintain an environment free of accident hazards.	F 323		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based	F 441		12/29/16

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F 441	Continued From page 17 precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 2	F 441	1. Resident #3 and Resident #4 will have perineum care according to professional standards. The CNA involved	

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F 441	Continued From page 18 of 5 sampled residents (Resident #3 and #4) observed during toileting/perineal cares. Failure to follow infection control practices while providing toileting/perineal cares has the potential to cause/spread infection. Findings include: Review of the facility policy titled "Perineal Care" occurred on 12/15/16. This policy, revised October 2010, stated, ". . . For a female resident . . . Wash perineal area, wiping from front to back. . . . . Do not reuse the same washcloth . . ." - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 10/19/16, identified severely impaired cognitive skills and extensive assistance of one or more persons required for toileting and personal hygiene. Observation on 12/13/16 at 10:35 a.m., showed Resident #3 in the bathroom. After the resident voided in the toilet, a certified nursing assistant (CNA) (#3) donned gloves, assisted the resident to stand, and provided pericares using a pre-soaked wipe. The CNA (#3) cleansed the resident's perineum from the pubis to the rectum, repeatedly using the same soiled wipe without turning it to a clean area. Per facility policy, the CNA (#3) failed to use a different area of the cleansing wipe or obtain a fresh wipe when cleansing the resident's perineum. - Review of Resident #4's medical record occurred on all days of survey. The annual MDS, dated 11/18/16, identified intact cognitive skills and extensive assistance of one person required	F 441	in deficient perineum practice was educated regarding proper cleansing technique and clean surface of washcloth/wipe with each cleansing stroke. 12.16.16. 2. All residents who have assistance with personal hygiene have the potential to be affected. 3. Perineal Care Policy reviewed and revised. 12.16.16 an educational booklet regarding proper perineum care was distributed at nurses station 1 and 2 for review and signature sheet attached to each booklet for individual signatures after the review. Poster were placed at nurses station 1 and 2 and also the staff dining room as a reminder to complete the perineal instruction. Booklet for CNA review and signature to be completed by 12.31.16. Proper perineum technique reviewed at nursing staff meeting 12.29.16. 4. Perineum observation/audits will be completed by QI manager, DON and/or designee weekly x4, monthly x2 and quarterly x4. Any observed deficient practice will be addressed at the time of the perineum care observation. QI manager will report results of the observations to QA Committee at each Quarterly QA meeting for 4 quarters. 5. 12.29.2016.	

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F 441	Continued From page 19 for toileting and personal hygiene. Observation on 12/13/16 at 10:35 a.m., showed Resident #4 in the bathroom. After the resident voided in the toilet, a CNA (#3) donned gloves, assisted the resident to stand, and provided pericares using a pre-soaked wipe. The CNA (#3) cleansed the resident's perineum from the pubis to the rectum, repeatedly using the same soiled wipe without turning it to a clean area. Per facility policy, the CNA (#3) failed to use a different area of the cleansing wipe or obtain a fresh wipe when cleansing the resident's perineum. During an interview on the morning of 12/14/16, issues pertaining to infection control were discussed with administrative staff members (#2 and #4). The administrative staff members provided no additional information related to perineal care.	F 441		