STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165605	A. BUILDING _____ B. WING _____	C 04/26/2017

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KENNYBROOK VILLAGE	200 SW BROOKSIDE DRIVE GRIMES, IA 50111

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F 000	INITIAL COMMENTS Correction date 4/27/17 Investigation of facility-reported incident #67300-I resulted in the following deficiencies. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C	F 000		
F 155 SS=K	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 155		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted 5/12/17 NK

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F 155	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, review of policy and procedures and viewing of the facility surveillance camera, the facility failed to provide an intervention of an advanced directive for 1 resident that requested CPR (Cardiopulmonary resuscitation). The facility reported a census of 31 residents and 4 of the 31 residents requested CPR (Resident #1, #6, #7, #8). Findings include:	F 155	Past noncompliance: no plan of correction required.	

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Resident #1 had a quarterly Minimum Data Set (MDS) assessment with a reference date of 1/17/17. The MDS identified the resident had a BIMS (Brief Interview for Mental Status) score of 15. A score of 15 indicated the resident had no cognitive problems. The MDS noted the resident required extensive assistance of 2 staff members for bed mobility and totally dependent with transfers. The resident's diagnoses included atrial fibrillation (irregular heart beat), coronary artery disease, hypertension (elevated blood pressure), paraplegia (loss of muscle function in an area of the body) and depression.

The Care Plan with an initiated date of 1/31/14 identified the resident requested to have a full code (CPR). The goal of the plan identified the resident's wishes would be respected. The interventions directed the staff that the resident did not want to be intubated but wanted CPR, medications and electro shock.

Review of a form titled CPR/DNR Authorization Form dated 01/11/15, indicated in the event that the resident should stop breathing or his/her heart stops beating, he/she chose the following: perform CPR, which means cardiopulmonary resuscitation will be administered.

Review of the form titled Nurse to Nurse Pre-Admission Report, dated 4/5/17, indicated Resident #1, was admitted with diagnosis of surgical repair of a left femur fracture.

Review of the Progress Nurses Note dated 4/5/17 at 4:00 pm indicated the resident returned from the hospital via a wheelchair. The note indicated the resident to be alert to whereabouts, made

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direct eye contact when talking with staff and followed directions. The resident appeared tired so the nurse suggested he/she lie down for a while rather than staying up in the wheelchair and the resident agreed to this. The nurse documented the resident's skin pale warm and dry, pulses palpable of arms and feet, but weak in feet. The nurse noted the resident had chronic vascular discoloration throughout the lower extremities.

Review of the Progress Nurses Notes dated 04/05/17 at 10:09 pm indicated evening medications administered and resident complaining of mild pain. Staff administered Tylenol (analgesic). The resident received and completed a menu. At meal time, the resident was sleeping so the meal tray was placed in refrigerator to reheat later when awake. At 6:00 pm the north hall nurse, Staff B, closed Resident #1's door due to the resident sleeping and peers wanted to visit. At 7:15 this nurse (Staff A, Licensed Practical Nurse, LPN) entered the room and described the resident's condition as: not responding to verbal or tactile stimuli. Staff A called for Staff B to affirm the initial assessment. The note identified the resident's body as: cool to touch; skin jaundiced, palpable pulses, blood pressure and respirations absent. Staff B advised Staff A to call the physician immediately. The physician gave verbal order not to initiate CPR. The physician accepted the assessment of death and ordered to call the Funeral Home of the resident's choice. The nurse notified the family and medical examiner.

On 4/12/17 at 2:56 pm Staff A was interviewed and stated she saw the resident when he/she arrived from the hospital and completed an

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F 155	Continued From page 4 assessment. Staff A stated the resident complained of pain and she administered the scheduled and the PRN Tylenol to the resident around 4:00 pm. Staff A stated she went back into the resident's room around 4:30-5:00 pm and applied Theragesic Cream to the resident's lower legs for complaints of pain. Staff A stated she gave the resident a supper menu and he/she completed the menu form. Staff A stated she did not see the resident again until 7:15 pm. At that time, Staff A described the following: The resident skin noted to be ashen, jaundice, mouth open with dentures falling out, stomach bloated, extremities cold, body cool to touch, knees down appeared purple/red. Staff A described no rigor mortis had set in, and the resident's extremities to be flexible. Staff A stated she knew the resident to be a full code but per her assessment at 7:15 pm, she decided not to perform CPR, as she stated nothing she could have done to bring the resident back. Staff A stated she stands by this choice, resident was her friend and nothing she could do to bring him back. Staff A stated her assessment of the resident took her 5 to 10 minutes to complete. Staff A stated she left the resident's room to get Staff B, RN, to assess the resident. Staff A stated Staff B came to the resident's room and assessed the resident and told her to call the resident's physician immediately. Staff A stated she called the physician and answered right away. Staff A stated she informed the physician of her assessment and the physician instructed her not to start CPR. On 4/12/17 at 3:51 pm and 4/13/17 at 4:26 pm Staff B was interviewed and stated she saw the resident around 5:00 pm at supper time in bed and complained of being tired. Staff B stated she next saw the resident around 6:00-6:15 pm and	F 155		

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F 155	Continued From page 5 the resident refused a room tray. Staff B stated she went to the resident's bedside and he/she requested his door shut. Staff B stated she instructed dietary to put the tray in the refrigerator for later. Staff B stated the next time she saw the resident was 7:15 pm after Staff A came to get her. Staff B stated she immediately went to the resident's room and described the resident as: absence of breathing, pulse, hand and feet cold. The resident's arms laid on abdomen and felt warm. The resident's skin appeared jaundice with a blue color around the mouth; abdomen distended and felt fluid present. The resident's mouth open with dentures falling out and slumped over the left side. Staff B stated due to her assessment and her clinical experience, the resident was too far gone for CPR. Staff B stated her assessment took her 1 to 2 minutes to complete. Staff B stated she had never had a resident code (cardiac arrest) under her care. Staff B reported she instructed Staff A to call the resident's physician and give assessment of the resident's condition. Staff B stated the physician immediately answered the phone and after Staff A gave her assessment of the resident, the physician told them to not initiate CPR. Further interview and facility surveillance review revealed Staff B entered Resident 1's room at 5:29:20 and in room for 5 seconds. When Staff B was asked about this she stated she went into the resident's room to say hello and the resident was still alive, covers pulled up over her/him up to abdomen area, lying on back with arms over abdomen, awake, talking to her. Review of the facility surveillance video dated 4/5/17 revealed the following: - At 5:16 pm the hair dresser entered Resident	F 155		

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F 155	Continued From page 6 #1's room and exited at 5:17 pm. -At 5: 29:20 pm Staff B entered resident's room and exited 5 seconds later. -At 5:46 pm Resident #9 entered Resident #1's room and exited 30 seconds later. -At 5:49:36 pm a resident ambulated towards the resident's room. Staff B closed the door without entering and the resident went the other direction. -At 7:08:10 pm Staff C, Certified Nurse Aide (CNA) entered the resident's room and exited 36 seconds later. -At 7:14:03 pm Staff A, LPN, entered the resident's room and exited at 7:14:46 pm. -At 7:15:43 pm Staff A entered the resident's room and exited at 7:16:08 p.m. -At 7:21:34 pm Staff A and Staff B entered the resident's room and exited at 7:23:24 pm. -At 7:37:48 p.m., Staff G entered the room and exited at 7:40 p.m. -At 7:43:40, Staff G returned to the resident's room. -At 7:47:04, Staff A and what appeared to be family, entered the room. NOTE: The video did not show a supper tray delivered to the resident's room on 4/5/17. An interview was conducted on 4/14/17 at 11:20 am with Staff B. Staff B was asked about the facility surveillance on 4/5/17 at 5:49:36. The surveillance identified she did not enter Resident #1's room but blocked a visiting resident from entering the room, and closed the room door. Staff B replied "I'm sorry; well I did go all the way into the resident's room, to the resident's bedside". An interview was conducted on 4/14/17 at 11:28 am with Staff D, hair dresser. Staff D stated she	F 155		

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F 155	Continued From page 7 stopped to see Resident #1 after she/he returned to the facility. Staff D stated when she entered the resident's room; she/he slept soundly with eyes closed and covers on. Staff D stated she did not go all the way into the room to the resident's bed side. Staff D stated she did not speak to the resident and the resident did not say anything to her. Staff D stated she then left the room. An interview was conducted on 4/13/17 at 2:45 pm with Staff C, CNA. And stated after reviewing the video surveillance, she did go into Resident #1's room at 7:08:10 pm. Staff C stated she was working on the other side of the facility and looked for gowns when Staff B told her to check in the resident's room. Staff C stated she went to the resident's room and found the resident lying in bed, and had one eye open. Staff C stated she did not say anything to the resident nor did the resident say anything to her. Staff C stated she did not go up to the resident's bedside and did not find any gowns. During a second interview on 4/26/17 at 2:35 p.m. with Staff C, she stated she did not recall if Resident #1 laid on his/her back in bed or on side when she entered the room looking for gowns. Staff C stated the resident had 1 eye open and mouth open but don't recall if dentures came out of mouth. Staff C stated the resident probably laid on back. Staff C stated Staff B had sent her to the room to look for gowns as she thought maybe gowns were in that room. On 4/26/17 at 1:30 p.m. Staff G, CNA, was interviewed and stated she worked the day Resident #1 returned from the hospital. The staff assisted the resident in transferring to the bed and positioned the resident on back with pillows on side. The resident had oxygen per a	F 155		

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concentrator. At 5:30-6:00 p.m. Resident #1 asked her to rub ointment on legs so she informed Staff A. Staff G stated around 7:15 p.m. she saw Staff A coming out of the resident's room and she appeared worried, and she could tell something was wrong. Staff G stated she asked Staff A if the resident was okay and Staff A did not reply. Staff G stated she could see the resident from the hall and the resident laid on his/her back with blanket pulled up to abdomen. Staff G stated she saw Staff A and Staff B at the nurse's station looking in the resident's chart. Staff G stated she was asked later to give Resident #1 post mortem care. The resident was cold but not too cold, a little warm, not stiff, his mouth opened with dentures protruding out and skin pale. Staff G stated she did not see CPR performed.

On 4/12/17 and 4/13/17 the DON (Director Of Nursing) was interviewed and stated the staff follow the AHA (American Heart Association) for CPR. The DON stated she stood behind Staff A and Staff B decision to not perform CPR on Resident #1 as the resident had signs of lividity and rigor mortis and dependent lividity. The DON stated the time discrepancy of Staff A's assessment time of Resident #1 of 5-10 minute assessment is not correct per video surveillance, and Staff A is not very good at estimating time. The DON stated the AHA guidelines indicated to do CPR if the body is warm with no pulse or respiration. The DON stated staff should not do a blood pressure check before initiating CPR. The DON stated she did educate the staff of the facility CPR policy starting on 4/7/17 to ensure staff are all on the same page, just in case something would come up.

On 4/13/17 at 7:35 am the Assistant Director of

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F 155	Continued From page 9 Nursing (ADON) was interviewed and stated she would perform CPR on a full code resident if the resident showed signs of life. If not would not do CPR per AHA. The ADON stated Resident #1 was a full code. Review of the letter dated 4/6/17 and signed by the physician, indicated she was called at 7:16 p.m. on 4/5/17 by the facility nurse. The nurse shared with her the resident was "gone" and found to have no pulse and not breathing, cold to touch and very pale. The letter indicated the nurse informed the physician she had seen the resident an hour and 15 minutes before finding the resident pulseless and the nurse felt the resident had been dead a while. The physician ordered CPR not to be given based on the conditions and the description already cool, suggesting pulseless for perhaps an hour. Review of the facility's Resuscitation Policy (not dated) included: -Cardiopulmonary Resuscitation (CPR); refers to a range of procedures used to attempt to restore heartbeat and breathing following a cardiopulmonary arrest. Basic CPR refers to a means of opening and maintaining an airway, providing ventilation through rescue breathing and providing artificial circulation through the use of external cardiac compression. - Upon determination that a resident is in cardiopulmonary or respiratory arrest (note time), CPR will be immediately initiated by nursing staff and 911 called for advance cardiac life support unless one of the exceptions applies: a) When the resident or surrogate has indicated that resuscitation is not desired and the attending physician has issued a written do not resuscitate (DNR) order that is maintained in the facility's	F 155		

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F 155	Continued From page 10 clinical record; or b) When there is the presence of obviously clinical signs of irreversible death (defined as rigor mortis or dependent lividity); or c) There are no physiologic benefit can be expected because the vital functions have deteriorated despite maximal therapy for such conditions such as progressive septic shock or cardiogenic shock. d) When attempts to perform CPR would place the rescuer at risk of personal injury. - If CPR is required, it will be immediately initiated by any staff member currently certified to perform CPR, pursuant to current American Heart Association guidelines. 2. The quarterly MDS assessment for Resident #6, dated 01/24/17, revealed the resident had a BIMS score of 8. A score of 8 identified the resident moderately cognitive impairment. The MDS noted the resident to be independent for bed mobility, transfers, ambulation, and required assist of one staff member for toilet use, and personal hygiene. The resident's diagnoses included hypertension (elevated blood pressure), non-Alzheimer's dementia, psychotic disorder, and schizophrenia (mental disorder). Review of Resident #6's face sheet identified the resident requested CPR code status. 3. The quarterly MDS assessment for Resident #7, dated 2/15/17, revealed the resident had a BIMS score of 12. A score of 12 identified the resident had moderate cognitive impairment. The resident's diagnoses included heart failure, hypertension, cerebrovascular accident, and asthma.	F 155		

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F 155	Continued From page 11 Review of Resident #7's face sheet indicated the resident requested CPR code status. 4. The quarterly MDS assessment for Resident #8, dated 2/7/17, revealed the resident had a BIMS score of 8. A score of 8 indicated the resident had a moderate cognitive impairment. The resident's diagnoses hypertension, hyperlipidemia, Non- Alzheimer's disease, depression, and lung disease. Review of Resident #8's face sheet indicated the resident requested CPR code status. Note: The Director of Nursing provided inservices to the staff about the resuscitation policy/procedures on 4/7/17. This was determined past noncompliance and the facility had corrected the immediate jeopardy on 4/7/17, following the inservices provided to the staff.	F 155		
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 (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.	F 323		

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F 323	Continued From page 12 (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: Based on record review and staff interviews, the facility failed to provide adequate supervision to ensure against hazards from self and elements in the environment (Resident #1). The sample consisted of 9 residents and the facility reported a census of 31 residents. Resident #1 went on an outing to a restaurant with 3 other residents, the activity director and van driver. The resident attempted to enter through a door and the threshold was raised and not accessible. The resident "rammed" the threshold and fell out of the chair. The resident did not receive supervision or assistance getting through the door. Findings include: 1. Resident #1 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 1/7/17. The MDS identified the resident had a BIMS (Brief Interview for Mental Status) score of 15. A score of 15 indicated the resident had no cognitive impairments. The MDS noted the resident required extensive assistance of two staff members for bed mobility, dressing and toilet use, total dependence on assistance of two staff members for transfers, set up assist for	F 323		

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KENNYBROOK VILLAGE	200 SW BROOKSIDE DRIVE GRIMES, IA 50111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

eating and for locomotion off the unit. The MDS indicated the resident had functional impairment of both lower extremities that placed resident at risk for injury. The resident's diagnoses included anemia, atrial fibrillation, coronary artery disease, hypertension (elevated blood pressure), gastroesophageal reflux disease, neurogenic bladder, diabetes mellitus, arthritis, osteoporosis (condition when the bones are weak and brittle), paraplegia (muscle weakness), and depression.

The resident's Care Plan identified a focus area with an initiated date of 1/15/16. The focus area identified the resident at risk for falls related to debility and paralysis. The care plan identified a focus area on 8/27/14 and revised on 1/18/16 that the resident used a power wheelchair for independent mobility in and out of the facility. The interventions included and directed staff that the resident is independent with the use of the power chair and can go independently when the weather is nice. The staff are to educate the resident of safety

Review of a form titled Witness Fall dated 3/30/17 at 11:58 a.m. indicated staff received a phone call from the Activities Director, Staff E. Staff E reported Resident #1 out on outing to a local restaurant in motorized wheelchair. Per report, resident slid out of wheelchair onto the floor inside of the restaurant. Resident reported no pain or problems at the time and requested to be allowed to stay at the restaurant to eat meal before returning to the facility. Resident denied injury to the Activity Director who was present and the resident asked that they [non-facility personnel] get him/her up from the floor and put him/her back into the motorized wheelchair. The resident assisted by non-facility personnel back

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F 323	Continued From page 14 into motorized wheelchair and maintained his/her wish to stay at the restaurant to eat although Activities Director strongly encouraged return to facility for further assessment. Resident returned to facility around 1:00 pm in his/her wheelchair and voiced complaints of right hip/knee pain and rubbing the right upper leg. Resident recounted events, stating him/her having trouble getting wheelchair through the threshold of the restaurant. Resident reported having to move his/her wheelchair backward and forward to get a run at the doorway and the wheelchairs back wheels went over the threshold and the wheelchair hit the building causing resident to fall to floor. Resident reports legs being bent underneath him/her and at the time having no pain. Resident asked people to help him/her back into wheelchair so he/she could proceed with eating at the restaurant. Resident stated about 15 minutes into the meal, started to have pain in the upper right leg but wanted to stay at meal before returning to facility to be assessed. The Progress Nurses Notes dated 3/30/17 at 1:06 pm indicated Resident #1 reported he/she arrived at the restaurant and was moving motorized wheelchair through doorway when wheel got hung up on lip of doorway. Resident reported he/she then "backed wheelchair up and "floored it" and got through the doorway and causing him/her to fall out of wheelchair landing forward onto floor with legs folded underneath him/her. Resident reported he/she insisted on people to get him/her off the floor and back into wheelchair because he/she wanted to eat at the restaurant. The resident reported developing pain about 20 minutes later to the knee and thigh area. Upon return to facility resident transferred from wheelchair to bed via Hoyer lift (mechanical lift)	F 323		

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F 323	Continued From page 15 per his/her normal with right leg supported, and ice applied to right leg. Resident had scheduled Tylenol while eating. The nurse notified the physician and received order to have x-ray's done. The x-rays completed at 2:40 pm and the physician ordered for resident to be transferred to the emergency room for further evaluation and treatment. Review of the Operative/Procedure Report dated 4/3/17 indicated Resident #1 was in a motorized wheelchair 4 days ago and fell out of wheelchair. Resident brought to emergency room due to pain and deformity of leg. Resident diagnosed with femur fracture. Surgery recommended and family elected to proceed with surgery. The x-rays identified chronic severe osteoarthritic changes of the right hip and femoral head and neck (hip). The right hip had comminuted (pieces) fracture of the femoral shaft (femur-thigh bone). The surgery consisted of repair with rod and nail to the right femur. Review of Staff F's statement, volunteer bus driver for the facility, reported when entering the restaurant, the entrance had about a 1 inch threshold at the bottom of doorway. Resident first tried to go in forward in motorized wheelchair and could not get in. Then resident tried to go in backwards and still not able to get into building. Staff F then told the resident the threshold keeping him/her from getting in and resident said "let me try going through forward again". The resident did get in the first door after several attempts. The resident's wheelchair got caught on the second door and stopped the wheelchair causing him/her to slide out of wheelchair on to floor and legs. After this, the resident said we need to get him/up off the floor to wheelchair	F 323		

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F 323	Continued From page 16 because of leg hurting from being bent. Staff F reported he and the owner of the restaurant picked resident up of the floor by lifting him/her under the arms and placing the resident onto wheelchair. Staff F reported after getting the resident back into wheelchair he asked resident if he needs to transport him/her back to facility and resident said no, and Staff F asked resident if his/her leg still hurting and resident replied no. Staff F reported assisting the other residents from the bus into the restaurant and then sat across the table from Resident #1. Staff F stated the resident then reported his/her knee hurts and Staff F asked resident if it hurt enough for him to transport resident back to facility and resident said no. Staff F than asked resident if his/her motorized wheelchair had a seatbelt and resident said yes but he/she does not use it. Staff F reported the resident continued to eat dinner okay and took home leftovers. Staff F stated no problems were encountered for the resident leaving the restaurant and retuning to the facility. Further review of the Incident Fall Report dated 3/30/17, indicated facility reviewed events with the emergency department and resident. Feel that when resident does go out on outings he/she should place motorized wheelchair into manual mode and have staff assist him/her over difficult passages/thresholds to avoid this from happening again. The report indicated the therapy are to reassess resident's safety with operating motorized wheelchair. The facility Incident Report on Witnessed Fall dated 3/30/2017, indicated a statement from the restaurant server. The restaurant server reported she witnessed the fall of Resident #1 and reported the resident "rammed" his/her wheelchair into the doorway and slid out of the	F 323		

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F 323	Continued From page 17 wheelchair onto the floor. The server stated the resident wanted to get up off the floor and she went to go get assist from another restaurant worker. The server stated Staff F and another restaurant worker assisted the resident off the floor and back into wheelchair and the resident went to a table in the restaurant. Review of the Fall Scene Investigation Report dated 3/30/17 at 11:15 to 11:30 am, indicated staff who witnessed the resident's fall from the facility to be Staff E, Activity Director and Staff F, bus driver, and from the restaurant personnel to be the female server. Factors observed during the time of fall indicated environmental factors of motorized wheelchair forced over lip of doorway on floor causing resident to be tipped out of wheelchair to floor. The resident got his/her wheelchair caught on the lip of doorway and resident backed up and took a run for it and dumped self out of wheelchair. The resident reported "got caught on lip of doorway in wheelchair, I backed up and floored it and hit the lip of doorway and dumped myself onto right side". The cause was a mechanical fall due to running into static object. Resident lost control of wheelchair. Feel this is isolated event. Resident not in a familiar place and forced his/her wheelchair through doorway which made the wheelchair out of control for resident, hitting wall/doorframe causing fall from wheelchair. Interventions included for the resident to not speed through lipped doorway, therapy to reassess resident's safety with driving motorized wheelchair, resident not using best judgement or technique with use of wheelchair. Spoke with Activities Director about turning off wheelchair into manual mode for assisting resident through difficult passageways.	F 323		

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F 323	Continued From page 18 An interview on 4/13/17 at 9:04 am Staff E, Activity Director, stated she always calls first to a restaurant to ensure they are handicap accessible and she did this prior to the outing on 3/30/17. The restaurant said they were accessible. Staff E stated this is the first she has taken residents to this restaurant for an outing. Staff E stated Resident #1 was the first off the bus and she remained on the bus with the other residents. Staff E stated the bus driver, Staff F, went ahead of the resident and opened the front door for him/her. Staff E stated the doorway was narrow and there was immediate decline slope once inside the doorway to the second doorway that was very close. Staff E stated they left the facility around 10:45 am to the restaurant that is only a couple miles away from the facility. Staff E stated there was a total of 4 residents attending the lunch outing, 1 motorized wheelchair, one manual wheelchair, and 2 resident independent with ambulation. Staff E stated she could see the resident attempting to go through doorway several times and said "we are going to have to go back" as resident not able to get through doorway. Staff E stated the resident insisted and she got out of the bus and went to doorway as Staff F held door open. Staff E stated she did not offer help to the resident and neither did Staff F, nor did the resident ask for help. Staff E indicated the resident backed up wheelchair to get a running start to get through doorway and when doing this the resident hit the threshold causing him/her to bounce up in wheelchair and losing control of his/her motorized wheelchair, and hitting the second doorway door and causing the resident to fall to floor. Staff E stated Staff F kept telling the resident to slow down before he/she fell out of wheelchair, but the resident did not listen.	F 323		

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F 323	Continued From page 19 Staff E stated the resident landed on his bottom with legs bent towards his/her right side and wheelchair behind him/her. Staff E stated the resident requested to lifted back up into his/her wheelchair and denied any injury. Staff E stated Staff F and a male restaurant worker lifted the resident up, from the floor, from under his/her arms into wheelchair. Staff E stated she told the resident we needed to go back to the facility so he/she can be assessed but the resident refused. Staff E stated she called the facility and reported this incident and they told her it was ok to stay and complete the lunch outing. Staff E stated after the resident finished his/her meal, he/she complained of knee pain. Staff E stated the resident always went out on outings and would operate his/her motorized wheelchair in high mode, very fast, and Staff F would always tell the resident to slow down. Staff E stated she assumed the facility knew the resident operated the wheelchair in fast mode as she saw the resident also doing it in the facility. An interview was conducted on 4/13/17 at 10:55 am with Staff F, volunteer bus driver. Staff F stated Resident #1 went out on outings often and when he enters the van he goes very fast causing him/her to bump into bracket on the lift. Staff F states he tells the resident to slow down and sometimes he/she will and other times not. Staff F stated he did not know the resident had a seat belt in wheelchair until after this incident. Staff F stated when they arrived at the restaurant for lunch outing, Resident #1 was first off the bus and he held the first door open for the resident and the second door was propped open. Staff F stated before the resident attempted to enter the doorway he asked the restaurant for a ramp to get into first doorway and they said they don't	F 323		

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F 323	Continued From page 20	F 323		

have one. Staff F stated he told the resident to try going into doorway forward and a wheel of his/her wheelchair got stuck on the threshold. Staff F stated he told the resident to try going in backward and again he got stuck on the threshold. Staff F stated he told the resident then that he/she was not going to get into restaurant and resident said let me try one more time. Staff F stated the resident backed up about a foot and with wheelchair in high and ran up over the threshold causing the resident to pop up from wheelchair and losing control of wheelchair, hitting the second door frame and causing resident to come to an immediate stop and falling forward to floor. Staff F stated the resident did not ask for help to get into doorway and he did not offer due to the wheelchair being heavy and he did not want to hurt his back and known the resident does not like wheelchair touched. Staff F stated he did not know the wheelchair could be put into manual and push assist be provided. Staff F stated the resident requested to be picked up off the floor and he and a restaurant worker picked the resident up from under his/her arms back into wheelchair. Staff F stated the resident told him he/she was fine and wanted to eat at the restaurant. Staff F stated the restaurant, after being picked up of the floor and back into wheelchair, proceeded to the table in the restaurant and did not want to leave to return to facility until after the meal.

Interview with Resident #9 on 4/13/17 at 3:45 pm revealed the resident had been to the restaurant before and the doorway is bad. The doorway is dangerous and had a very hard time getting his/her motorized wheelchair into the restaurant.

Photographs of the door threshold appeared

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F 323	Continued From page 21 raised and not acceptable for a person not supervised and without assistance in a wheelchair.	F 323		

Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged, or that any regulatory violation occurred.

The following is to be considered our Credible Allegation of Compliance.

F323

Kennybrook Village will ensure that our residents will remain as free from hazards and accidents as possible and that all residents will be adequately supervised to prevent accidents. When Kennybrook Village conducts an outside of the facility activity, the Activity Director will ensure the location of the activity will be free of any risks that would likely result in harm to our residents, by way of calling ahead or, when applicable visiting the location prior to the activity. Based on the

care needs of the residents, the Activity Director will identify if additional staff are required to accompany the residents to off-site activities.

The Director of Nursing will monitor for compliance on a monthly basis.

Completion Date:

4/27/2017